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Maternity Nursing in Hospital and Home

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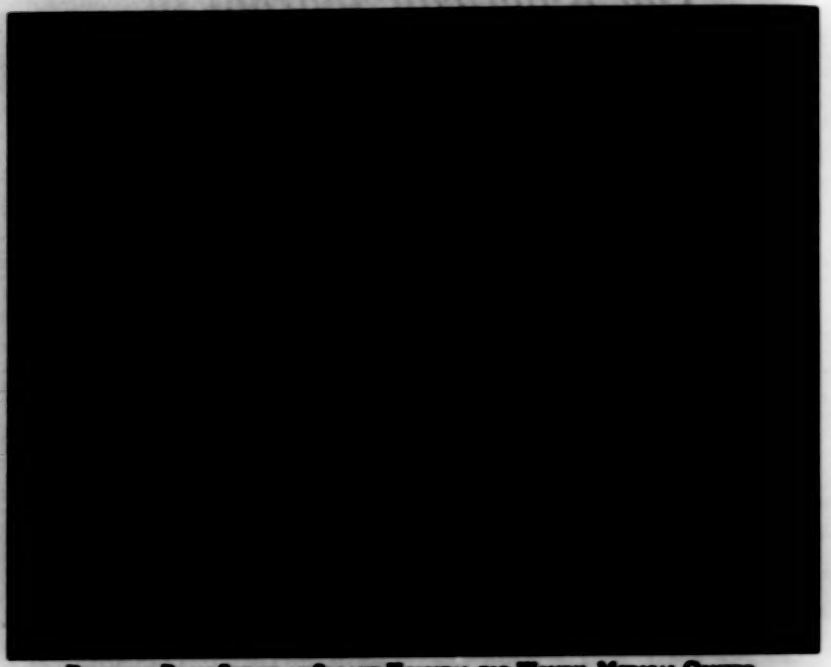
THE aim of adequate maternity care is to secure for every pregnant mother the minimum of mental and physical discomfort throughout pregnancy, the maximum of mental and physical fitness at its termination, with a well baby and the knowledge whereby to care for her baby.

Theoretically, every nurse should know obstetrical nursing when she leaves the school of nursing; unfortunately few do. Most student nurses see the maternity patient for the first time when she comes to the hospital in labor, care for her from ten to fourteen days, and do not see her again after she leaves the hospital. Every pregnant mother needs care for at least ten months. The nurse gets very little idea of the need for continuous supervision over this ten-month period of prenatal and later care when her contact with maternity patients covers a period of two weeks or less. This means that nurses may know delivery-room technic, nursery routine and postpartum bedside care, but practically nothing about care and supervision during pregnancy or the days that follow after the mother leaves the hospital.

The nurse in a properly organized and administered general hospital will have an invaluable opportunity of seeing the most effective, efficient, and economic ideals of general and obstetrical nursing. The equipment at command embraces, in some instances, the very best in existence, and its very perfection may make her fearful of situations where it is lacking. The instruction she receives, however, is the last word of command in the battle against invalidism and death. She carries out into the world at least this source of power for service, and she will use it in an infinite variety of ways. She will find that under the most unfavorable conditions of dirt and poverty, the principles of obstetric nursing, if applied conscientiously, can secure equally safe results.

In many cities there are a large number of obstetrical patients that are cared for by out-patient departments of the hospitals, clinics and dispensaries, or in coöperation with the visiting nurse associations or various other agencies, such as infant welfare organizations, maternity centers, health departments, Red Cross service, etc. The nurse may or may not be present at the actual delivery, but she prepares the patient for delivery, and secures the conditions outlined for private cases, as nearly as possible, by the exercise of originality and



DELIVERY ROOM SET-UP AT SLOANE HOSPITAL FOR WOMEN, MEDICAL CENTER, NEW YORK CITY

Note the following: (1) Comfortable mattress. (2) Extension table may be moved away after patient has been put into position and used for the baby if necessary. (3) Apparatus for giving anaesthetic is kept in drawer of delivery table. (4) Baby patch bed with electric heating pad. (5) Extraordinarily good lighting. (6) Operating lighting. (7) Operating room attendants masked. (From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1929 by J. B. Lippincott Company.)

judgment. If she is present at the delivery, she assists the doctor in the usual routine way.

In any of these situations, where the nurse often has to work alone, she will find use for the fundamentals of nursing she acquired in her hospital training and for many improvisations to suit the various conditions she meets. She is often asked by community boards, patients, and others for advice on many questions. She may have had no previous training bearing on these special questions, but she should at least know where such information may be obtained.

Such improvisations as the following have been pictured and explained and other essentials have been reduced to a simple inexpensive form:

Improvised cuspidor or paper pan for waste (made of newspaper).
Improvised bed pads made of old pieces of material tacked over newspapers.
A unique "Kelly pad" made from newspapers and oilcloth.

The baby's bed may be a bassinette or basket, but a trunk tray, bureau drawer, or two chairs arranged safely together, may be used to keep the new baby warm, which is so essential at this time.

KITCHEN SET-UP FOR A DELIVERY IN THE HOME

(Picture taken through courtesy of Maternity Center Association, New York City. From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1929 by J. B. Lippincott Company.)

1. Kitchen sink
2. Liquid soap
3. Hand scrub
4. Cornucopia
5. Paper napkins
6. Nurse's bag on newspaper
7. Hot boiled water with knife
8. Cooled boiled water covered
9. Set tub open for waste solution
10. Paper pan for waste
11. Baby's toilet tray
12. In bed for baby; set of clothes, receiving blanket kept warm by hot water bottle
13. Oil, set in basin of warm water
14. Rectal thermometer and scales on paper napkin
15. For care of baby; folded blanket or pillow protected by newspaper covered with diaper and pinned
16. Care for baby near open heated oven
17. Emergency

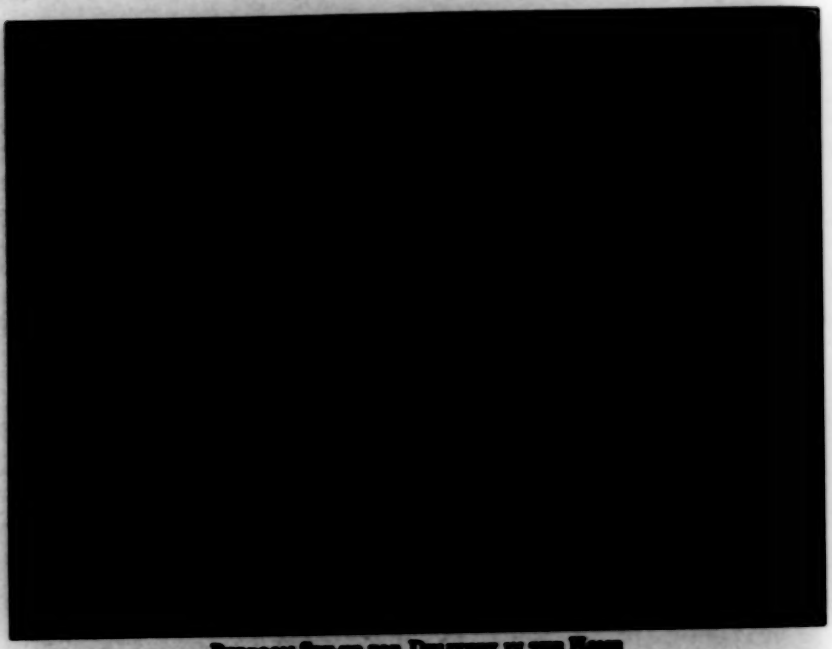
The toilet tray may be purchased, or made up at home from supplies from the kitchen which will not be missed. The tray in the illustration, for example, is simply a washboard covered with a pillow-slip pinned to fit.

The Baby's Bath

THE baby's bath should be one of the pleasures of the day for the mother or nurse and for the baby. It should be planned for a time when forty-five minutes of uninterrupted attention can be given by the mother. At first this can best be done before the nine or ten o'clock morning feeding; but if it is more convenient the bath may be given before any feeding.

Cautions for Bathing.—There are four things to keep in mind in giving the baby his bath.

(1) Prepare everything before you take the



BEDROOM SET-UP FOR DELIVERY IN THE HOME

(Picture taken through courtesy of Maternity Center Association, New York City. From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1929 by J. B. Lippincott Company.)

1. Delivery bed. Firm mattress supported by board; protected by oilcloth or papers
2. Extra blanket for patient
3. Paper pads for protection
4. Top bedclothes fanned to far side of bed
5. Paper pan for waste sponges
6. Extra sheet for draping patient
7. Improvised tray with delivery supplies
8. Pads
9. Sponges
10. Silver nitrate
11. Sterile cord set
12. Chair protected by newspaper
13. Solution basin for doctor's hands
14. Solution basin for patient
15. Sterile cotton wrapped in clean towel
16. Sterile vulva pads
17. Sterile hypodermic syringe in basin
18. Spotlight
19. Improvised cone for anesthetic
20. Vaseline
21. Paper napkins
22. Irrigation tray, Mason jar or pitcher, Lysol, teaspoon
23. Supplies on dresser; dresser protected by newspaper covered with towel
24. Clean basin for placenta between newspaper
25. Douche pan between papers
26. Extra paper; pan for waste

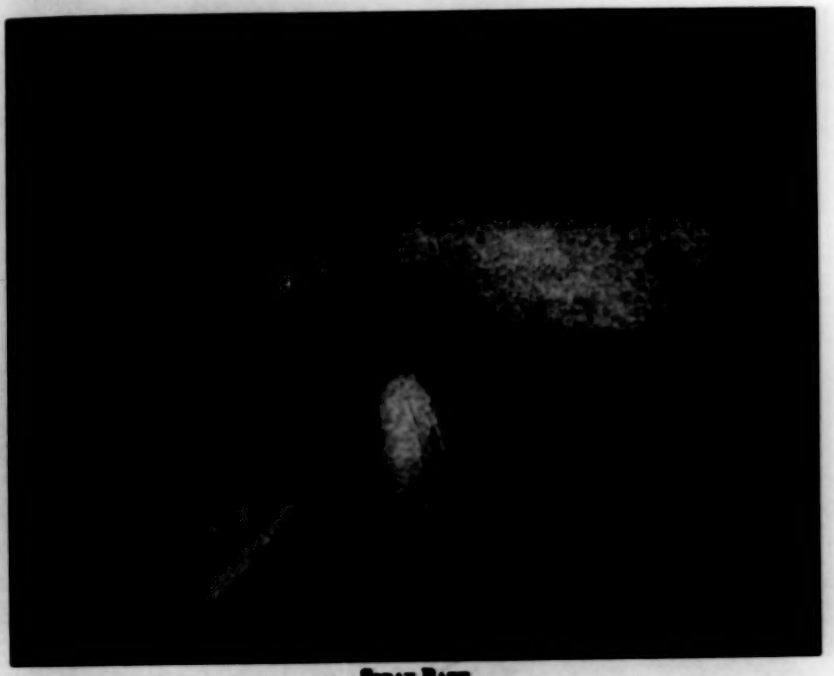
baby. This makes it much easier for the mother or nurse and for the baby.

(2) Bathe him as quickly as possible, so as not to chill or fatigue him. His bath should be refreshing and should never be given so slowly as to irritate him.

(3) The baby should be handled and turned as little as possible.

(4) Be sure you are comfortable while bathing him.

The room should be warm, about 72° F. On cold days this may be managed by bathing the baby before an open fire or open heated oven. It is well to sit so that his little feet may



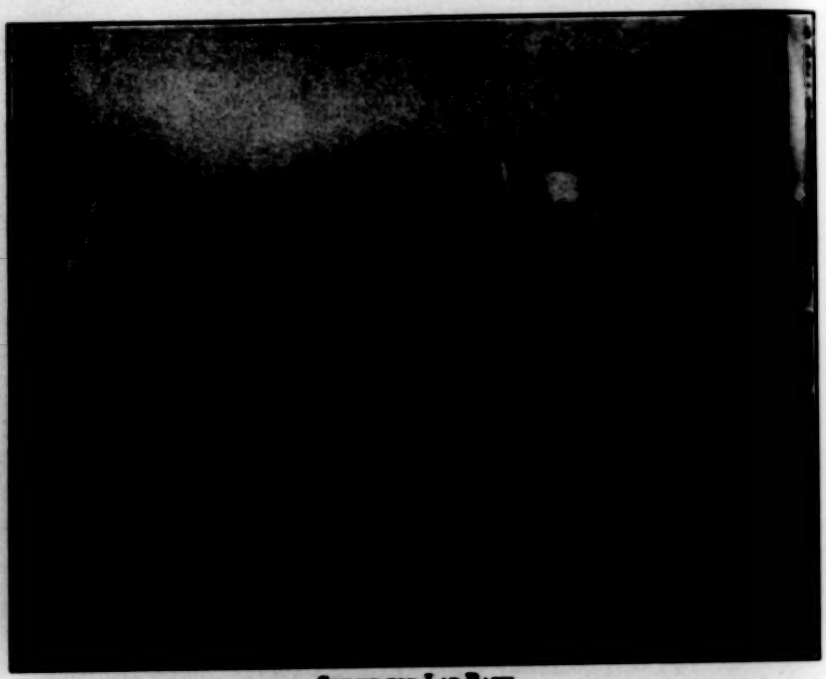
SPRAY BATH

The baby is first soaped and then held on the arm during the spray bath. Note the heated table at right on which the baby may be dressed, with shelves for keeping the clothes warm, and a side shelf on which to lay things. (Courtesy of Sloane Hospital for Women, Medical Center, New York City. From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1920 by J. B. Lippincott Company.)

be toward the heat, for if the baby's feet are cold, it may make him very uncomfortable and fretty. He should always be protected from drafts. An improvised screen may be made by draping a blanket or sheet over the back of two straight-back chairs. Have two low chairs without arms, one for you to sit on and the other on which to place the bathtub. (The tub chair may be either a chair or a firm stool.)

Equipment.—The baby's toilet tray should be placed conveniently for use. At the right should be all the things needed at bathing time: his bottle of cooled, boiled water, to give him before his bath; the small swabs to use for his nostrils, ears and genitals; his soap, cotton, oil, and a paper cornucopia in which to throw the soiled cotton. Then the complete outfit of clothing should be in readiness. These little clothes should be arranged, band, shirt, diaper, etc., with the petticoat inside the dress, to be put on as one garment. This saves handling the baby. On cold days, it will be a comfort to the baby if these clothes are warmed before they are put on.

A clean tub or basin—it should be about three-fourths full (or perhaps less) of warm water, about 100° to 95° F. for the new baby. The safest



SET-UP FOR LAP BATH

Recommended because mother sits while giving the baby his bath. Note the low chair without arms, and the bathtub at a convenient height. (From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1920 by J. B. Lippincott Company.)

method is to test the temperature of the water with a thermometer; this is not always possible, and in such a situation water that feels comfortably warm to your elbow or the back of the wrist may be used. The washcloth may be an old piece of soft clean linen. A bath blanket, bath towel and a soft clean face towel should be within easy reach. Have also a pitcher of hot water, so that some of it may be added, if necessary, to keep the water comfortably warm. It is a good plan to wear a waterproof apron (inexpensive, but not very lightweight, rubber aprons are good for this purpose).

Disposal of Soiled Clothes.—A newspaper should be spread out on the floor for soiled clothes; this keeps the soiled clothes together and does not soil the clothes nor the floor. Have, also, a covered pail of borax solution for wet diapers.

When all the preparations are complete, wash your hands thoroughly before beginning the bath, as described below.

Details of Bathing Process.—There are two ways of giving a young baby a bath—in the mother's lap or on a table covered with a pad or pillow. Either method is satisfactory if the baby is kept warm and comfortable. The bath given on the mother's lap enables the mother to sit while bathing her baby and is less fatiguing for her. The baby seems happier, more

SET-UP FOR A TABLE BATH

If the articles are arranged as shown at the end of the table, so that the baby lies between them, there is less chance of his rolling off the table. (From "Nurse's Handbook of Obstetrics," Zabriskie, copyright 1929 by J. B. Lippincott Company.)

comfortable and less frightened. The lap bath may be safer, for if the mother is called away she will instinctively pick up the baby if he is on her lap; whereas she might leave him unattended if he were on the table and he might roll off.

In picking up the baby it is essential to remember always that his little head and neck should be supported. While holding him, put his bed to air, then seat yourself comfortably with your knees together on a low chair without arms and give him his one ounce of cooled, boiled water. The bath should be given in the same order every day; not only because it may be given more quickly but the baby, too, learns this order and responds, before long, by putting a hand or foot up at the proper time to be bathed. Before undressing the baby cleanse his nostrils and ears with the small swabs of cotton that you have just dipped into mineral oil. If you hold his head with your thumb and forefinger just above his temples he cannot wriggle.

Inspect his mouth but do not wash it, as you may injure the tender mucous membrane. Remove his dress and pettiskirt, loosen the neck of his shirt and cover him with the bath blanket. Tuck the little face towel under his chin and wash his face with warm water, no soap, and pat dry with this soft towel. The eyes are washed as part of the face or as we wash our own. Should there be a discharge,

boric acid solution may be used, but such a condition should be reported to the doctor at once. The scalp and ears, and especially the skin behind the ears, are washed with soap and water; and these may be rinsed by holding his head over the tub. Carelessness in cleansing the scalp will result in the condition known as *seborrhœa capitis*. This is due to an oversecretion of the sebaceous glands; and the fat or oil mixed with dirt, forms a yellowish-brown, waxy-looking crust on the head. This will never occur if the child is properly cared for. When the condition is found, the crusts should be gradually washed with warm sweet oil, and removed as gently as possible; afterward, if the head is kept clean there will be no return of the trouble. Dry thoroughly by patting and by wiping gently in the creases. Remove his diaper and cleanse the buttocks with oil. If his bowels have moved, put the diaper on the newspaper for care later. If it is wet, only, put it into the covered pail of borax solution. Then finish undressing the baby, and wrap him in his blanket to prevent chilling. If his clothes are soiled, place them on the newspaper for disposal later; if they are not soiled, they may be thoroughly aired, sunned, and used again.

His body should then be soaped, with your hand, only one part being uncovered at a time, to avoid chilling. Special attention should be paid little creases of the neck, under the arms, the creases at the elbows, especially in between the fingers and toes and in the groin.

You are now ready to put him into his tub. To do this place your left hand under his head so as to support the head with your left hand and wrist, and your fingers spread out to support his shoulders and hold the arm. Let the baby sit in your right hand and put him into the tub very gently, feet or buttocks first. Putting the baby into the water gently keeps him from becoming frightened, as he may be if he is plunged suddenly into the water. If the baby's arm and shoulder are firmly held and supported by your left hand, it is very easy to steady his entire body and keep his head and ears out of the water. Keep him in the tub two or three minutes or just long enough to rinse him thoroughly, paying special attention to the creases in the neck, under the arms and in the groin. Be sure his little fingers and toes are also thoroughly rinsed. (As the baby gets older he may stay in his tub five minutes or longer.) Remove him from the tub, holding him in the same way as when putting him into the water. Wrap him in his bath towel and blanket and pat him thoroughly dry—not forgetting the creases—and drying carefully between the fingers and toes. If a tiny bit of mineral oil is carefully rubbed over the entire body and then any excess removed with the soft towel, it helps to keep his skin lovely and fresh. Powder may be used, if the doctor prefers it. Slip out the wet towel and put on his knitted band and shirt. In putting on this band, it is well to draw it on over the feet. If the baby is a boy baby, as we have been calling him, his foreskin should be retracted by gently rubbing it back with cotton, taking pains that it is pulled forward into its original position after the part underneath has been cleansed with oil. If the foreskin is tight, the doctor should be consulted. If it is a girl baby, separate the labia and cleanse with oil. If there is any discharge, report it to the doctor.

Dressing Following Bathing.—There are two methods of putting on the diaper. In one, it is folded diagonally; and in the other, it is folded

rectangularly. The latter type, or square diaper, is more comfortable for the baby and is much easier to wash, as it becomes soiled in only one spot.

The baby's dress and pettiskirt are put on as one garment, so as to have the fewest possible motions. His hair should be brushed upward from his neck and backward from his forehead. He should be wrapped in a small blanket, ready to be nursed. If his feet and hands are cold, a hot water bottle (125° F.) with a cover may be placed at his feet.

At night, the baby's face, hands and buttocks may be bathed and his little back rubbed.

Usually he wears a shirt, band, diaper and light, loosely woven nightgown, which has a draw string in the bottom to prevent him from becoming uncovered.

A Study of Breast Care

A Reduction in the Incidence of Mastitis from 4.49 Per Cent Out of 980 Cases, to 2.88 Per Cent Out of 936 Cases

M. CORDELIA COWAN, R.N.

Part I

The reasons for undertaking the study of breast care were to ascertain what scientific measures could be instituted (1) to prepare the breasts to function normally; (2) to present a method of breast care during the puerperium that would give greater protection from infection; (3) increase the comfort to the mother; (4) reduce the time and materials needed to carry out the procedures. The medical and nursing literature on breast care, published since 1920, was reviewed to obtain the current ideas and practices relative to good breast hygiene, and a comparative study was made of two methods used in the nursing care of the breasts during the puerperium to bring out the superior points of the advocated procedures.

Hygiene of the Breasts

FOR logical consideration the hygiene of the breasts might well fall into the following periods: early infancy, adolescence, pregnancy, and the puerperium.

Early Infancy

During the first few days of life, the breasts of the newborn infant contain a minute amount of thin watery fluid, the so-called "witches' milk" by the Germans. This fluid is to be found in the breasts of the male newborn as well as the female; it is similar in nature to the colostrum in the mother's breasts. Similar to the engorgement in the mother's breasts, also, is the engorged condition of the infant's breasts, sometimes encountered, occurring at about the same time. This is now thought to be due to the endocrine stimulation from the mother's ovaries before the infant's birth. Great care needs to be exercised to avoid any injury of the infant's breasts at this time, especially in the female, as later on the scar tissue might lead to difficulties at the time of lactation. The infant's breasts may be treated as the mother's are, namely, by use of slight pressure and cold applications. Enough pressure can be obtained from a snug, but not tight-fitting, band of sufficient width to come up well over the breasts, and a tiny ice bag may be devised from the wrist and palmar

portions of an old rubber glove by firmly tying the open ends and partly filling the bag with very finely chopped ice. However, the greater tendency in treatment is to leave the breasts strictly alone, and under no consideration to squeeze and handle them unnecessarily. Given a few days' time and no injury from handling, the engorgement subsides of itself.[1 and 2]

Adolescence

At the time of adolescence, when the new endocrine substance from the ovary is being poured into the system, a marked change in the growth and development of the breasts takes place. During this period of glandular development there is a rounding out of the entire figure so that the breasts, like other portions of the body, come to have an increased amount of fat tissue. Depending upon both the amount of glandular tissue and fat tissue, the breasts vary in shape, even at an early age. Where the breasts are smaller and made up almost entirely of glandular tissue they are hemispheric and prominent, but where the fat tissue is in excess the breasts tend to sag and vary greatly in their contour. Quoting Dr. Lilian K. P. Farrar:

> Much harm has resulted the last few years from the type of brassière which flattens and pulls the breasts downward. Not only has this bad type of brassière caused loss of the normal contour of the breasts and an abnormal sagging, but it has also produced cystic conditions of the breasts of young women.

Many such cases have come under Dr. Farrar's care, and she has found that a large share of these cystic conditions have cleared up by wearing a proper supportive type of brassière. This fact seems to suggest, as good prophylactic care, the use of such a type of brassière in order to maintain the normal contour and condition of the breasts if they are large and tend to sag.

Pregnancy

With the advent of pregnancy the breast glands take on a new growth and development. Some are of the opinion that the growth is due to a hormone developed in the ovum, while others think that the growth is due to the stimulation from the developing corpus luteum.[3] Each gland made up of its fifteen to twenty lobes, subdivided into lobules or small clusters of acini, enlarges, loses the hard tenseness of the virginal gland, and becomes much softer. About the fifth week of pregnancy the patient becomes aware of the enlargement of the breasts and their increase in blood supply by a feeling of heaviness and tingling. The increase of blood supply is accompanied by an increase in the size of the vessels, as is manifest in the more plainly visible veins. There is also an hypertrophy of the lymph system in the breasts to take care of the increased blood supply. Beginning during the first few weeks, there is a darkening of the areola, the pigmented area surrounding the nipple, and enlargement and more erectile condition of the nipples, and an increase in size of the tubercles of Montgomery, the tiny milk glands within the areola and surrounding the nipple. During pregnancy a marked development takes place in the acini, the secreting structure in the breast gland, with an increase both in the number of cells and in their size. By the third or fourth month of pregnancy the secreting structure of the breasts may begin to function so that colostrum can be expressed. Along

[1] DeLee, Joseph B., "Principles and Practice of Obstetrics," p. 357.

[2] Van Blarcom, Carolyn Conant, "Obstetrical Nursing," p. 550.

[3] DeLee, Joseph B., "Principles and Practice of Obstetrics," p. 105.

with the increase in glandular structure there is an increase and softening of the connective tissue, and as the breasts become heavier they tend to sag more. With the increasing size of the breasts, an overstretching of the skin may result in the line-like scars called linea gravidarum. The theory has been advanced that, besides this preparation for lactation, the development of the breasts creates an internal secretion that seems to inhibit ovarian activity.[4]

With these changes going on in the breasts and in order to prepare them for the function of lactation which they are to perform, certain points in their care are indicated.

1. As the breasts become larger and tend to sag, a supportive type of brassière is needed to maintain their normal circulation and condition and also to afford greater comfort.

2. The nipples, being more erectile, will need to be protected from pressure and the friction of the clothing. A tiny "doughnut" made of cotton and wrapped with a narrow bandage will afford much comfort and protection from friction which injures the delicate skin of the nipples.

3. If the nipples are flat, stunted, or not prominent enough for successful nursing, drawing out with the fingers and shaping at the bathing time may remedy the condition.

4. The routine application of all substances that tend to irritate and increase the dryness of the skin should be avoided, as irritant soap, glycerin, alcohol, alcoholic preparations, etc.,[5] and [6]

5. But the tender, delicate skin of the nipples can be made much tougher during pregnancy by daily washing with non-irritant soap and water, followed by a brisk but gentle rubbing with the towel and an anointing with some oily substance (cold cream, olive oil, etc.) to replace the oil of the skin that was removed by the washing. This special washing of the breasts, to be most practical, should be at the regular bathing time, and is best started during the early part of pregnancy when the patient feels more comfortable and it is easier to institute new habits. This washing also serves to remove dried colostrum which might otherwise become a source of irritation and give rise to sore nipples.

Puerperium

The puerperal period ushers in lactation and again the breasts undergo changes thought to be due, possibly, to the disappearance and absorption of the corpus luteum.[7] For the first few days after delivery, colostrum is present in the breasts, a thin yellowish fluid that is high in albuminous material and salts, but which contains less fat than is found in normal milk. The function usually attributed to the colostrum is its laxative effect upon the infant, but more recent opinions are that the serum albumin in the colostrum is of important nutritive value and that the englobulin content is absorbed directly into the blood, carrying with it certain protective antibodies in which the infant is deficient.[8] The amount of colostrum is small, and it is secreted very slowly to fill the lactiferous ducts or main canals leading from each lobe to their orifices on the surface of the nipple. Nursing periods before the establishment of the milk, therefore, should not be more frequent than every four hours, and less frequent if the breasts are greatly engorged, because the nursing aggravates the discomfort if not the actual engorgement itself. As the infant gets only a teaspoonful or so of colostrum at a nursing during the very beginning of the period, it is futile to have it nurse for longer than three to five minutes before the milk is established, as nursing subjects the nipples to unnecessary friction when there

[4] DeLee, Joseph B., "Principles and Practice of Obstetrics," p. 105.

[5] Hodgson, Amy, "The Technique of Breast Feeding," *Practitioner*, Vol. CXVII, p. 98, August, 1926.

[6] Russell, Violet L., "Treatment of Sore Nipples in Lactating Women," *Lancet*, Vol. II, p. 1299, December 20, 1924.

[7] DeLee, Joseph B., "Principles and Practice of Obstetrics," p. 105.

[8] Williams, J. Whitridge, "Obstetrics," p. 394.

is little or no secretion. From this friction abrasions may result providing pathways of entrance for infection.

Anywhere from the second to the fourth or fifth day there is a marked rush of blood to the breasts that results in a lymphatic and venous stasis, the so-called simple engorgement of the breasts. This increase of blood causes the breasts to feel hot, heavy, and tender. Especially where the breasts are large and pendulous, support from a breast binder, preferably put on immediately after the first preparation of the breasts for nursing, can prevent much discomfort by holding them in a position that facilitates good circulation. While a very small amount of milk may be formed spontaneously, the establishment of the milk can only come by the stimulation from nursing of the infant, or by expression or pumping of the breasts. Where there is no stimulation, the milk is not established and in a few days the engorgement subsides. If the baby is stillborn or dies, the discomforts of the engorgement period can be considerably lessened by using a tight binder, applying ice bags, limiting but not restricting fluids, and giving a saline cathartic if ordered by the physician. The purge, however, is not considered by all as essential, and many deem it an added discomfort to the patient that might well be dispensed with.[9]

Principles of Breast Care During the Puerperium

Establishment of the Milk Supply

In order to establish a good milk supply it is necessary that: (1) The proper mental attitude of the mother should be created and maintained; (2) She should be in good health, well nourished, and comfortable; (3) The nursing periods should be regular; (4) The breasts should be entirely emptied at each nursing.

[9] Larkin, Charles L., "Drying up of the Lactating Breasts," *Medical Journal and Record*, Vol. CXXV, p. 527, April 20, 1927.

Much can be done to obtain the desirable attitude of the mother toward nursing her baby by pointing out the importance of the proper food for the newborn. Investigations and studies such as those made by the Children's Bureau at Washington become enlightening information when they can be related in a simple fashion to the mother. It was found in a study of 22,423 live-born babies by the Children's Bureau that the mortality in artificially-fed infants was between three and four times as high as that among the breast-fed. The same study further showed how a breast-feeding education plan, that had been worked out and used in Minneapolis, has definitely increased breast feeding in that city.[10] The proper mental attitude, once gained, must be maintained by allaying unnecessary fears and worries which exert a depressing effect upon the milk secretion. The new mother may be unduly disturbed over the temporary deficiency, especially at the very beginning of lactation and at the time of getting up after being confined. Assurance and simple explanations of the beneficial influence upon the milk supply, gradually brought about by the mother's return to normal living habits, can go far to relieve this mental stress. It is important, too, that the mother's unhampered activities be considered, as this may be a reason for her unwillingness to nurse her baby. It is especially true of the modern woman, who wishes to continue her work outside the home. This situation can be met by giving the baby one or two substitute bottle feedings daily. It is advisable to begin these substitute feedings early, not only to give the mother greater

[10] Hesselbaum, E. J., "Breast Feeding," *American Journal of Nursing*, Vol. XXIV, p. 751, September, 1924.

freedom but also to make it less difficult should artificial feeding have to be resorted to, as, for instance, in case of the illness of the mother.

For the maintenance of the mother's good health, attention must be paid to diet, rest, sleep, and elimination. It has been estimated that food to yield about 750 to 1,000 calories is needed, in addition to that required to meet the nursing mother's own needs. Some investigations of the influence of diet upon lactation show better results from a limited increase of protein rather than too much increase of the carbohydrates and fats, the latter apparently increasing the calorie intake of the mother without increasing the food for the infant.[11 and 12] Through other studies it has been found that the amount of vitamin B needed for lactation is greater than that needed for growth.[13] More water should be taken, but too much liquid food should be avoided, lest it upset the digestion. To overcome the sluggish condition of the bowels the diet should include a high proportion of residue type of food. If waste products are retained within the system they tend to produce a general sluggish state that affects the breasts as well as the other secreting organs. However, it must be borne in mind that cathartics are depleting, and to remedy poor elimination by their administration is to decrease the milk supply.[14] Therefore, good elimination should be furthered through regular habits, diet high in cellulose, plenty of water to drink, graded exercises, and, if needed, a small simple enema every second day.[15]

But even the best influences upon the milk supply from these good hygienic measures may be greatly lessened if the mother is uncomfortable during the nursing period. To afford the greatest comfort to both mother and baby the best position for the mother, when lying down to nurse her baby, is to turn into the lateral position with the arm of that side up under her head. In this way she can better prevent her breast from pressing against the baby's nose and cutting off its air supply, thus avoiding the danger of suffocation. If the infant's air supply is even partially shut off, he drops the nipple and, in order to take another hold on it, subjects the nipple to additional and unnecessary friction. After the mother is able to sit up, in or out of bed, she can hold the infant by crossing the knee of the side at which the infant is to nurse so that she rests her forearm against her thigh as she holds the baby while nursing.

Stimulation of the breasts by nursing, by expression, or by pumping is an absolute essential for milk production. Because milk is formed at the time of stimulation, the nursing periods must be regular and the breast must be emptied each time.

Frequency and Duration of the Nursing Periods

Investigations during the last few years have led to many new conclusions about the time, frequency, and duration of the nursing periods. Because both the mother and the baby

[11] Adair, F. L., "Influence of Diet on Lactation," *American Journal of Obstetrics and Gynecology*, Vol. IX, p. 1, January, 1926.

[12] Fisher, Maud, "Postnatal Maternal Care," *Journal of American Medical Association*, Vol. LXXXIX, p. 2023, December 17, 1927.

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[14] Bowling, T. F., "Postpartum Care of the Puerperal Woman," *Texas State Journal of Medicine*, Vol. XXIII, p. 491, October, 1927.

[15] McPherson, Rose, "Care of the Bowels During the Puerperal Period," *American Journal of Obstetrics and Gynecology*, Vol. LXXX, p. 686, December, 1919.

are in need of a rest period, the first nursing of the newborn should be six to eight hours after its birth. From the time of the first nursing until the milk is established, nursing periods for three to five minutes every four to six hours are sufficient. At present there is considerable difference of opinion relative to the night feeding, but the tendency seems to be toward its omission for the normal infant. By continuing to omit the night feeding after the milk is established, the mother is given a better chance to rest and the baby is started in its habit of sleeping through the night, a very important habit, where the new mother, getting up after her confinement, has to assume immediately the entire responsibility of her baby. Examination of the milk at stated intervals during the nursing period shows a variation in its composition, with the last part of the milk being much higher in fat. This milk, which is richer in fat, is essential for the nutrition of the infant and, if not removed by washing, leaves an oily coating over the nipple which replaces the oil removed from the skin by the nursing of the infant.

By weighing babies at stated intervals, after nursing for five, ten, and twenty minutes, it has been possible to determine the length of time needed for the nursing period, and it has been found that the infant receives almost its total feeding during the first ten minutes. It follows that twenty minutes is quite ample for each nursing. A longer period is not only of no value to the infant, but may macerate the skin of the nipple. Through an experiment carried on at the Woman's Hospital, in the state of New York, in 1925, it was found that normal babies thrived and made as good gains in the long run on the feeding every four hours as did those that were fed every three hours. In addition, the engorgement of the breasts and irritation of the nipples were less noticeable, and the babies and mothers were more comfortable than on the three-hour schedule.[16]

Prevention of Infection

Since the greatest danger to the lactating breast comes from infection, every precaution should be taken to avoid bacterial contamination of the nipples. The chief sources of contamination are through handling the breasts by the patient herself and through faulty technic of the nurse in her care of the mother's breasts and the infant's mouth. To gain the mother's coöperation, the reasons should be made plain to her when she is instructed not to handle her dressings, namely, that the lochia is exceedingly infectious material. It has been found that bacteria thrive in the saliva from the infant's mouth, so if bacteria are introduced into the infant's mouth, it, in turn, may become a source for infecting the mother's nipples.[17] But by keeping the breasts clean, permitting only clean things to come in contact with the nipples, and allowing nothing to be placed in the baby's mouth but clean nipples of the mother or sterile nipples of bottles, bacteria have lessened chances of being carried to the mother's nipples. And since practically this whole responsibility of prevention of breast infection rests upon the nurse, the matter of the nursing procedures becomes most important.

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To be continued.

The New Nurses' Home and School of Nursing

St. John's Hospital, Springfield, Ill.

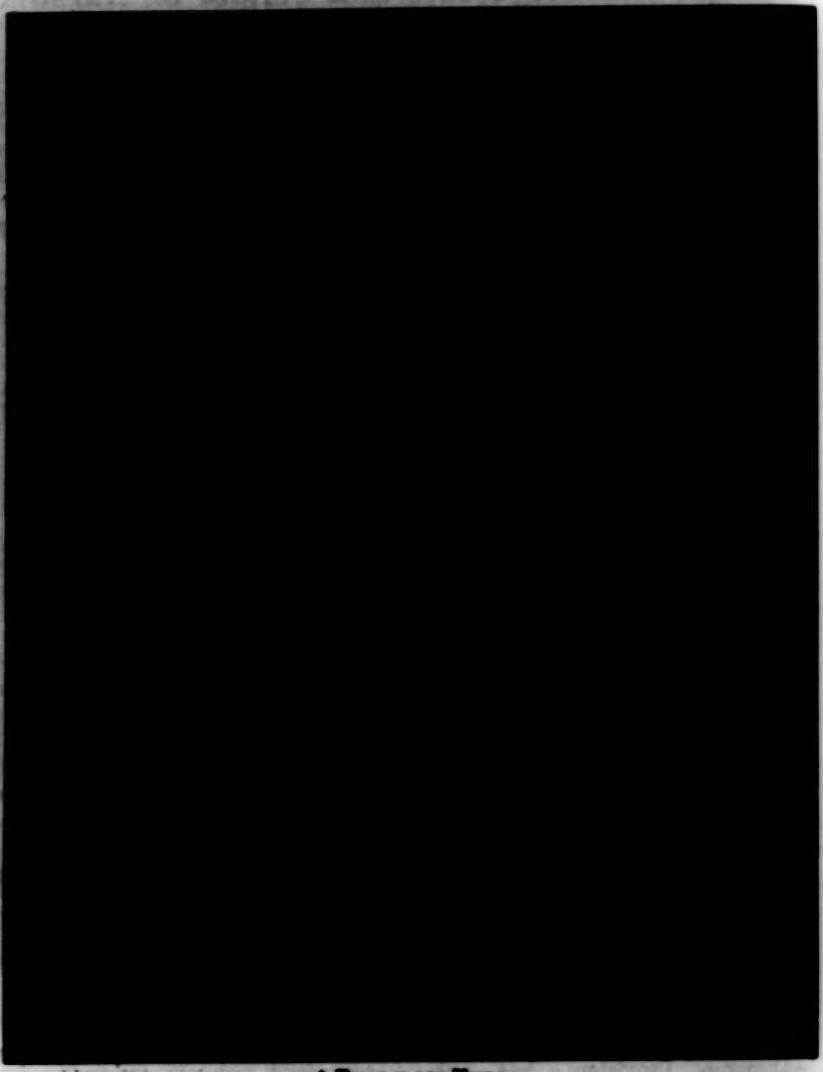
SISTER MAGDALENE, R.N.,

THE new Nurses' Home is a building nine stories in height, with individual bedrooms for one hundred and eighty student nurses, twelve suites and individual bathrooms. Provision has also been made to add three more stories whenever this becomes necessary. The building is entirely detached from the hospital group except for a one-story connecting corridor which unites all pavilions. The building has no basement. The main entrance opens through a vestibule and then into a spacious lobby, which is very homelike and inviting. There is an air of comfort and homeliness here in the deep soft rugs. The cosy chairs and sofas everywhere bid you welcome. The windows, curtained and gracefully draped in a crimson damask, allow enough daylight to enter to display here and there the rich texture of the walnut-panelled walls and massive columns.

Nurses' Home and School.

On one side is the reception room,

October, 1909



A First-floor Vista

which is entered through wide open doors; it is known as the "old rose" room. The heavy rug on the black and white blocked terrazzo floor is in rich oriental design, and the chairs and sofas are all upholstered in rose mohair.

On the other side of the lobby is a small formal dining room for the use of the students for private parties. It is indeed a gem, so perfect in its appointment and color scheme. The top half of the walls is of a soft mottled green,

the lower half beautifully panelled in walnut. The windows are festooned in a gold and green damask and the rug resembles a rare old piece of tapestry.

The dining-room suite is of an oak and walnut combination richly carved. Adjacent is a kitchenette.

Occupying one entire wing of the first floor is the main lounge, which is one of the chief features of this floor, and the most elaborate room in the home. The floor is of a beautiful terrazzo resembling marble. The panelled wainscot, with a marble base, is broken up at one side by a fireplace with a stone mantel and a stone chimney breast. Much thought and time have been given to every detail in this room. The period is Jacobean, with octagonal columns and heavily carved rococo ceiling. Blue and gold is the central color scheme with a bright spot, such as a red love seat, a green lounging chair, a rust-colored sofa, two stately English Manchester chairs in gold and crimson, placed here and there to give warmth and cozy comfort. Rich, deep-pile domestic oriental rugs are found where most needed. In one corner is a new baby grand piano, and back of it a very unusual spun-glass, Chinese screen. A radio and a victrola are also found in this room. The most colorful spot of all is that in front of the huge stone fireplace which reaches to the ceiling and on which is carved, in relief, a large likeness of the nurse's emblem with the word "Duty" across it. With such a motto in mind, who could fail or shirk?

Passing into a corridor we then enter a long library, in which the windows are draped with olive green damask fringed with green and gold tassels. The tables and chairs are arranged for conference, study and reading at one end, and rows of books in cases reach to the ceiling at the other. Here the student nurse has at her disposal reference books, encyclopedias and a host of bound nursing literature.

Formal Dining-Room for Group Parties

Across from the library is located the oratory, which is large and spacious.

A little further on to the right is the laundry, equipped with the most modern appliances obtainable, for the students' use only. In this same corridor are located the private telephone booths.

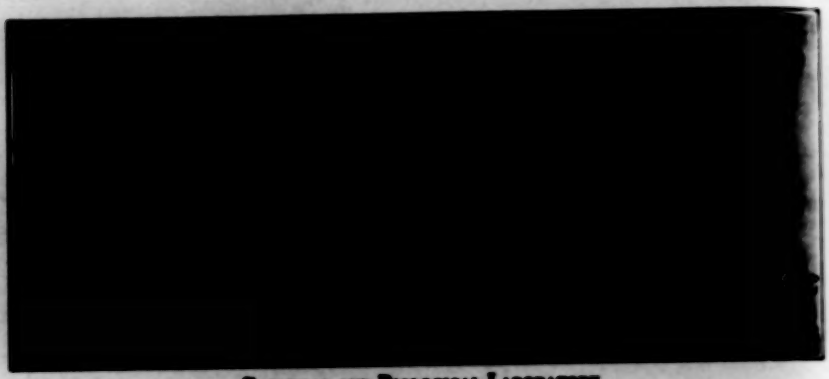
Special Entrance for Traffic

IN the center of the building, near the stairs and elevators and across from the lobby, is the control and business office. Here all nurses register in and out, and all the activities of the home are centered and governed.

Along this corridor are also located the individual offices for the School faculty.

Educational Division

PRACTICALLY the entire second floor is given over to the Education Department, and consists of three



CHEMICAL AND BIOLOGICAL LABORATORY

large classrooms, demonstration room, and a chemical laboratory furnished with the very latest equipment. It will accommodate forty students. The equipment for this room was provided by the Alumnae Association and cost $4,000.

For convenience, the diet laboratory is located next to the special Diet Therapy Department in the hospital.

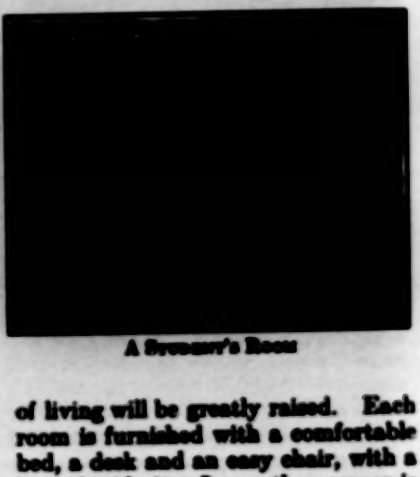
The biological laboratories have also been located close to the pathological laboratories of the hospital. Near these is the general lecture hall, which is used for special lectures for the whole student group, as well as for the physicians and other outside educational activities.

Six Entire Floors with Private Bedrooms

FROM the third to the ninth story, a typical floor plan has been worked out. Each floor consists of twenty-eight private rooms for the student nurses, two suites of two rooms and bath for the graduate nurses. There is a large cosy living-room in the center of each floor.

Toilet facilities with bathtubs and showers are provided in each wing of the floor. Clothes chute and dust chute open on each floor.

Each student's room is 8 x 13 feet and contains a large built-in closet and a lavatory with hot and cold water. Here comfort has been the keynote, and for the average girl the standard



A STUDENT'S ROOM

of living will be greatly raised. Each room is furnished with a comfortable bed, a desk and an easy chair, with a lamp beside it. In another corner is the spacious dresser. The window has a very pretty but simple valance and side drapery to take away any barren coldness. Some rooms are furnished in oak and some in walnut.

Recreation Hall

EXTENDING over the entire ninth floor, there is an informal recreation hall with its gaily decorated furniture, piano and victrola. At the windows are cheerful linen crash draperies with colorful flowered appliqué work. The slick terrazzo floor bespeaks a pleasant dance. Physical training classes receive their instruction here. The roof garden is located over one entire wing.

Two Elevators

THE conditions of elevator service are very severe.

The arrangement includes a large-car, switch elevator at 250 feet per minute speed, and a smaller, dual-control elevator at 200 feet per minute.

This permits car-switch service at peak loads and push-button service at those times when the traffic is light.

Let Our Babies Live

DURING the year 1928, the United States, which is fast approaching the time when it will really know its own birth and death rate, almost equalled the 1927 low record for infant mortality. In 1928, 68.3 babies died during the first year of life for every thousand live births. In 1927, however, we had an even better record of 64.9 deaths for every thousand live births. These figures are based on an analysis of the records of 719 cities within the Birth Registration Area. In the course of 1929 we hope not only to gain back the 3.4 which we lost in the preceding year but to register an even greater reduction.

Preventable infant deaths are still far too high in this enlightened and prosperous country. It is a triple loss—future citizens are lost to the country, the money which every independent citizen represents and that expended in immediate connection with childbirth is lost, and the time, strength and emotional force of the mothers and families of babies who die are total and irrecoverable loss. A woman who has suffered nine months of increasing discomfort, culminating in hours of intense pain, deserves not merely release from her physical misery but the fulfilment of her maternity. It takes only a little imagination to perceive how great a total of human suffering and emotional anguish exists in a country where 68.3 babies die out of every thousand that are brought living and breathing into the world (approximately 120,000 infant deaths in the entire country).

In one thing particularly, however, we have made marked progress. There are now forty-four states and the District of Columbia in the Birth and Death Registration Area. Fourteen years ago there were only ten states so registered. To know the number of births and the number and causes of deaths is the point of departure for remedial measures of the protection of health and the cure of disease that shall be state-wide in its effectiveness. That the remaining few states should come quickly into the Birth and Death Registration Areas is therefore a matter of highest importance. It is one of the first means by which we shall be able to bring down the number of baby deaths and the national misfortune resulting from them.

Is your state one of the four lagging behind?—S. J. Crumbine, M.D., in *American Child Health News*.

Group Nursing at Trinity Hospital

CAROLINE T. SNYDER AND MRS. MARTHA A. BROWN TETER, R.N.

TRINITY HOSPITAL, in Little Rock, Arkansas, a private general hospital of fifty beds, maintains no training school but has, for the past five years, used graduate group nursing exclusively.

The staff consists of six physicians who are owners of the hospital and who also constitute the Board of Directors. Only private patients of the staff are admitted, and cases of all types are accepted with the exception of certain mental and infectious ones. There are a few double rooms, but the majority of the rooms are single, and there are no wards. Adequate nursing is included in the room charge, and special nurses are employed rarely.

The group nursing is based upon a unit of twenty patients who are cared for by one day supervisor, one assistant day supervisor and six day floor nurses; one night supervisor and three night floor nurses. In addition to the nursing personnel there are a dietitian and a housekeeper who work in conjunction with the floor supervisor, and four colored maids who serve the trays and clean rooms.

The working schedule for the supervisors is as follows:

Day supervisor, 7 a. m. to 3 p. m.
Assistant day supervisor, 11 a. m. to 7 p. m.

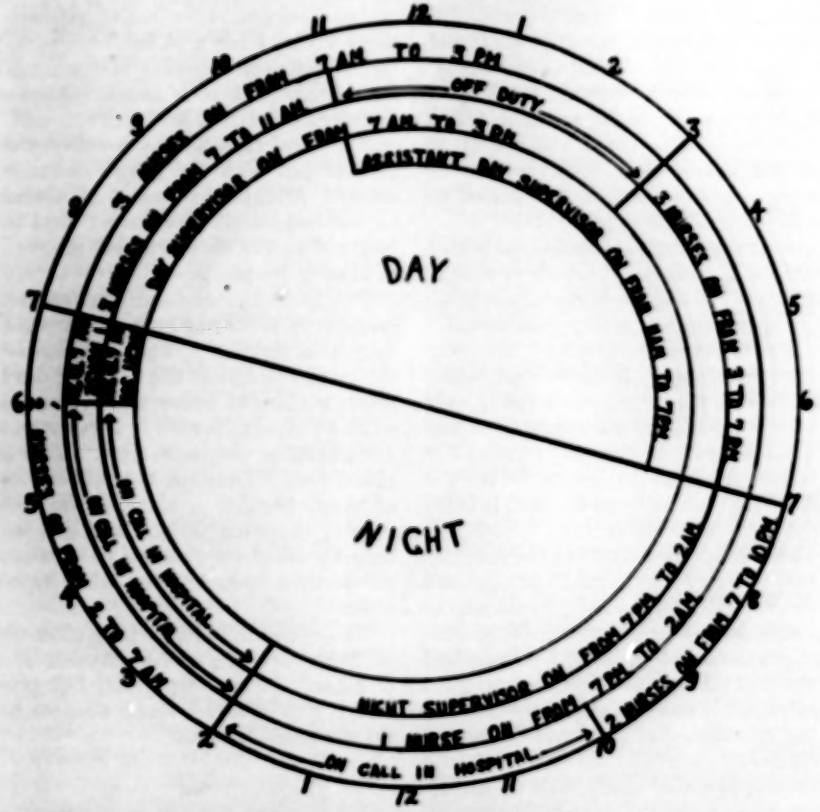
These supervisors exchange hours weekly, and are off duty alternately from 1 p. m., Saturday, until 11 a. m., Monday, each week. This daily schedule allows the day supervisor to visit the patients, supervise the corridors during the morning care of patients and, with the assistant day supervisor from 11 a. m. to 3 p. m., to relieve the floor nurses of all general duties not immediately connected with the care of patients, such as receiving visitors, giving information over the telephone and making rounds with doctors.

Each floor nurse has a certain number of patients assigned her, and she is responsible for them to the supervisors. All six day nurses come on duty at 7 a. m., and one of these is designated as "light nurse," from 7 to 11 a. m., to ensure quick response to lights, while the others are giving the patients their morning care. The light nurse also prepares patients for the operating room, gives hypodermics, etc. Three of these nurses go off duty from 11 a. m. until 3 p. m., at which time they return and work until 7 p. m., and the other three work straight through until 3 p. m., when they are off duty until the next day. This gives each nurse an eight-hour day, and the schedules for each group are alternated weekly, or as the occasion requires.

The six day floor nurses have one half-day off a week, viz.: two have Sunday afternoon, two have Sunday morning, and two have half-days during the week.

Each nurse does a two weeks' tour of night duty, in turn, which results in about four weeks of day duty to each two weeks of night duty.

The night supervisor comes on duty at 7 p. m. and works until 2 a. m., when she retires in the hospital (being available in case of emergency) until 6 a. m., working from that time until 7 a. m. Of the three night floor nurses, two go off duty from 10 p. m. until 2 a. m., and one from 2 a. m. until 6 p. m., all retiring in the hospital and available if needed. The night supervisor is off duty one night each week until 11 p. m. One of these nights each month she stays off the entire night. On her nights off duty



A Graphic Presentation of the Twenty-Four-Hour Rotation of Service for a Unit of Twenty Patients

until 11 p. m. the day supervisor working last hours comes on at 3 p. m. instead of 11 a. m. and works until 11 p. m. When the night supervisor has an entire night off, the day supervisor working last hours stays in the hospital all night on call. This plan keeps one supervisor on duty every hour of the day and night.

As stated above, this is a schedule for a unit of twenty patients and constitutes the permanent floor nursing staff. If the occupancy declines, this same staff is maintained, but if the occupancy rises, additional graduate nurses are employed, usually in the proportion of one nurse to three patients in the day and one nurse to five patients at night. To ensure adequate nursing care at all times, hourly nursing is occasionally used during rush hours.

The floor nurses receive $90 a month with meals and laundry of uniforms, no rooms being provided. This salary is increased $5 a month at the end of each year of continuous service, which results in a nurse receiving, in her fourth year, $105 a month.

Each supervisor and floor nurse is

allowed two weeks' vacation with full pay for each twelve months of service for the first two years; three weeks' vacation with full pay at the end of three years is the maximum. The vacation periods are so planned as to be continuous, one additional nurse being employed during this period to relieve for all vacations.

As previously stated, the cost of this nursing is included in the room charge of from $7 to $15 per day, and the nursing is exactly the same in all rooms.

Under this plan, and with the salaries mentioned, it has been found feasible to give a patient nursing care which is not only adequate from the standpoint of doctors and nurses, but which is quite satisfactory to the patients, all of whom are private patients and likely to be critical. The cost of this service to the hospital varies from $1.90 to $2.25 per patient for twenty-four hours. Patients, as a rule, have more confidence in graduate than in undergraduate nurses, and the cost of this plan to the hospital is but little more than that of a training school, as a graduate nurse can do more work and do it better, in a shorter space of time, than an undergraduate.

It has been difficult to persuade some patients not to employ specials, as newcomers in this hospital are loath to believe, from their former experiences in other hospitals, that adequate nursing can be obtained without a special; while practically all of them leave convinced that this is true, it occasionally happens that a patient is not satisfied without the entire time of a nurse, even though the floor nurse makes frequent visits to the patient's room without being called.

The greatest difficulty is in obtaining a desirable type of nurse. Nurses are plentiful, but it is sometimes difficult to obtain one who is not only well trained but with the proper attitude toward private patients. It seems almost impossible for some of them to forget a part of their training received in charity hospitals.

The plan has one curious feature, namely, that 75 per cent of the floor nurses are married. This is accounted for by the fact that the hours of duty allow a married nurse who wishes to work to indulge herself in a home and a husband at the same time. This is also desirable from the hospital's point of view, because a married nurse is usually more stable and less inclined to seek frequent changes of employment, thus reducing the labor turnover.

The above plan is the present result of five years of experimentation and changes. It is not perfect, but possesses, it is believed, many advantages for the small hospital.

Lip Stick

NINE varieties of lip stick were recently investigated by Health Commissioner Shirley W. Wynne of New York City in his effort to block the sale of impure cosmetics. These nine were picked at random from the ninety-odd varieties on the market. Each of the nine discovered to contain benzol, a poison highly irritating to the skin. As the average modern woman puts color on her lips at least five times a day, Dr. Wynne feels that the results of this investigation are not without significance.

What Do You Call Them?

HOW many new nurses are coming into the profession this year? On July 1, the Grading Committee started to find out. The figure was to have been published in this issue of the *Journal*. It seemed a simple task. All that was necessary was to find out how many students there were in the Senior classes being graduated this year. With 1,454 schools reporting full data to the Grading Committee, and with considerable supplementary data available about the rest, it should not have taken more than, say, two weeks at most to have discovered what nursing so greatly needs to know—how many new nurses are coming into the profession this year.

The count is still being made. It may possibly be finished by Thanksgiving.

One of the simplest of all questions to answer has proved almost excessively difficult, and for a curious reason: we cannot tell who a Senior student is. The schools were asked to report the number of students in the preliminary period, and in the first, second, and third years of training. Knowing that schools vary in their practice, other questions were also asked, so that there are, for each school, eight different ways of throwing light upon what the school really means by "preliminary," "first," "second," or "third" year. Accordingly, by rather elaborate cross-checking and computations, it will be possible for the Grading Committee to discover how many students will have been graduated during the school year 1928–1929; but the process will take a long time.

There are some schools which never have any third-year students. Graduation comes at the end of the second year, but that "year" may be 13, 15, 17, or 18 months long. In one such school, for example, a student is a preliminary student for 2 months, a first-year student for 13 months, a second-year student for 15 months, and she is then graduated without having entered her third year.

In schools all having the same length of course, the "third year" may last 0 months, 2 months, 3, 6, 6½, 9, 10, or 12, depending upon which school is being studied. While most nurses do not become Senior or third-year students until they have had at least 24 months of training, there are some schools in which students enter the third year after 16 or 18 months.

It is not only the "third year" which varies in the number of months it contains; the "second year" may be as short as 4 months or as long as 18; the "first year," 6 months to 13 months, and the "preliminary" period from nothing at all to 8 months.

Not counting the university schools, courses range from 24 to 48 months. Most schools have 36-month courses, and in those cases the second and third years are ordinarily 12 months long, but the preliminary period may be from one to eight. For schools with less than 36 months (for which the Grading Committee has reports from 55 in New York State, 40 in California, 12 in New Jersey, 9 in Connecticut, and 28 scattered in other states) there is an extraordinary variation. The following table, for example, shows different combinations in length of year, all reported to the Grading Committee by schools having 30-month courses.

"What does it matter how we divide our students, providing we ourselves know how much experience they have had?" It matters a great deal. The best guide the principal of

the nursing school has as to what tasks should be assigned her students is the experience of other principals, in other schools.

Months in "Year"							
Prel.		*1st. yr.*		*2d yr.*		*3d yr.*	
0	+	12	+	12	+	6	=30
0	+	12	+	18	+	0	=30
2	+	10	+	12	+	6	=30
2	+	13	+	15	+	0	=30
3	+	9	+	12	+	6	=30
3	+	12	+	12	+	3	=30
3	+	12	+	15	+	0	=30
4	+	6	+	10	+	10	=30
4	+	6½	+	12½	+	6½	=30
4	+	8	+	6	+	12	=30
4	+	8	+	8	+	10	=30
4	+	8	+	9	+	9	=30
4	+	8	+	12	+	6	=30
4	+	12	+	12	+	2	=30
4	+	13	+	13	+	0	=30
5	+	7	+	18	+	0	=30
6	+	6	+	12	+	6	=30

"We put our students in the operating room at the beginning of their second year." So? But does that mean at the 13th or the 18th month? It depends on what you call "second" year.

"Our Senior students learn ward administration by acting as head nurses." Does that mean after 18 months? or 24? or 28?

"Our preliminary students give eight hours a day to practice on the ward." By "preliminary" do you mean students who have been in training six months? Or only two?

The Grading Committee wants to know how many students are being graduated this year. The profession vitally needs that figure. Because the schools have no uniform system of classifying their students, the statements from the schools, though honestly made, are of little help. It is being necessary to examine the individual report sheet of every student nurse, calculate her unexpired time, and tabulate the totals for over 70,000 sheets. What should have taken two weeks is actually taking several precious months.

If the training-school nurses are eager to exchange experiences, to compare what they are doing with what others are doing, and so strive to raise the educational standards of their schools, and if they want to make future gradings possible without prohibitive expense, they must, as a first step, adopt some common language in which a given series of words will mean the same thing to everybody.

What an enormous help it would be, for example, not only to the Grading Committee, but to nurse educators everywhere, if "preliminary" always meant four months; if "first year" or "Junior" always meant eight months; if "second year" or "Intermediate" always meant twelve months; and if "third year" or "Senior" meant four months for a 28-months' school, six months for a 30-months' school, and twelve months for a three-year school!

Please note that these are illustrations, not recommendations! How long each section of the course should be is a matter for careful discussion. The decision should not be reached too hastily. But that nurses urgently need to consider and adopt a uniform method for classifying their students, is fully apparent from the work already done by the Grading Committee. Here is a task for the coming fall.

Blood Chemistry in the Study of Disease

ROBERT A. KILDUFFE, A.M., M.D.

THE destinies of human existence are governed by and dependent upon an interlocking chain of varied metabolic processes the integrity of which is essential, not only for the demands of health and disease, but for the very continuation of life.

While it has long been known that these metabolic processes upon which depend the vital triumvirate of nutrition, waste, and repair are chemical processes, it is only within comparatively recent times that feasible methods for their study have been elaborated, and only within the last decade or so have these studies been removed from the domain of purely experimental medicine and so perfected as to be clinically useful.

Microchemical determinations as applied to the blood have now assumed a recognized place as a definite means and part of the clinical study of disease, not only assisting in diagnosis and influencing prognosis, but also directing and indicating, under certain circumstances, rational methods of treatment.

While blood chemistry is still in process of evolution, while many of the methods now in use are open to further perfection and others still remain to be evolved, sufficient has been done to demonstrate beyond doubt the value and utility of those at hand.

It is impossible, for example, to understand thoroughly the clinical status of nephritis or to supervise intelligently the management of diabetes without recourse to blood chemistry, to mention the more common conditions in which it is of clinical value.

It is quite natural that the practical applications of blood chemistry have been first developed with reference to those conditions whose pathology and symptomatology are largely expressions of disturbance of renal function, because it is through and by means of the kidney that many of the chemical waste products of the body are excreted.

It must be remembered, moreover, that the blood is the great "common carrier" of the body, and that by means of its corpuscles and fluid constituents all the complex chemical entities required for bodily nutrition and growth, and arising from the concomitant metabolic processes of waste and repair, are transported. The blood, therefore, contains at all times a host of varied chemical constituents the ebb and flow and proportionate concentration of which reflect very accurately both the integrity and the disturbances of the metabolic processes in health or disease.

As practically all of the "normal" findings have been determined from the data secured by examinations made upon fasting subjects, determinations for clinical study should be made under similar circumstances; that is, when the patient has not ingested food for at least four to six hours.

There are obvious reasons for this precaution. It is well known that the products of digestion are absorbed and transported by the blood. Examinations made during the digestive period show definitely increased quantities of such important substances as glucose, fats, and the products of nitrogenous digestion. It would be obviously useless and misleading to compare these with "normal" findings secured during a resting period.

Blood chemistry determinations, therefore, are usually made upon specimens secured in the morning, before

breakfast. Where this is not feasible, the specimen may be taken not sooner than four hours after the last ingestion of food. Water may be taken at any time.

When patients are first seen in coma, however, the specimen is taken at once and without regard to the ingestion of food, for, if the chemical findings are abnormal, the abnormality (when due to disease and related to the coma) is so marked as to far exceed the normal variation consequent upon digestion.

Under certain circumstances food is deliberately administered before the collection of blood for chemical analysis. These are known as "tolerance tests," the purpose of which is to determine whether the functions in question are normally performed.

For example, the essential difference between a normal and a diabetic individual is the inability of the latter to dispose of carbohydrates in a normal fashion.

The administration of carbohydrates, followed by determinations of the blood sugar, constitutes a "sugar-tolerance test," a method of value in the detection of diabetes when marked clinical evidence is lacking.

When a normal individual ingests a definite quantity—100 grams—of glucose, a series of events takes place as follows: The sugar is rapidly absorbed by the blood and carried to the places normally used as reservoirs, namely, the liver and the muscles.

Shortly after the ingestion of sugar, there will be a sharp rise in the blood sugar content. As the sugar is rapidly removed under normal conditions within an hour, there will be an equally sharp fall to the level existing before the administration of the glucose.

In the diabetic, however, while the initial rise occurs, the faulty sugar mechanism fails to remove the sugar from the blood and, as a consequence, an hour or two hours later the blood sugar is still above the pre-test level. Instead of a sharp peak as in the normal reaction there is, therefore, a plateau when the determinations are graphed.

Specimens for blood chemical determinations must be liquid when received in the laboratory. An anticoagulant—sodium oxalate or sodium fluoride or a combination of both—is hence added to the specimen when it is taken.

The actual determinations are made upon a protein-free filtrate secured by removing all the protein from the whole blood which has been laked to rupture the corpuscles and free their contents.

The results are always reported in terms of milligrams per 100 centimeters of blood. A blood sugar of 120 mgms. per cent signifies, therefore, that the specimen contained 120 milligrams of glucose in each 100 cubic centimeters of blood.

The average normal findings are given in the table below:

Non-protein nitrogen—25–40 (plasma, 20–35).
Urea nitrogen—10–18 (plasma, 10–23).
Uric acid—1–3.5 (plasma, 2.5–5).
Creatinin—1–2 (plasma, 0.8–1.5).
Sugar—90–120 (plasma, the same).
Chlorides, as NaCl—450–600 (plasma, 570–600).
Cholesterol (Bloor) 170–280.

Not all of the determinations possible are listed above; only those more commonly utilized because their significance is more clearly defined.

It is impossible, within the scope of this paper, to discuss even in general terms the varied significance of blood chemical determinations. Enough has been said, however, to indicate their practical clinical value and to explain their increasingly general use.

While it is not the function of the nurse either to order blood chemistry determinations or to interpret the findings, she has, nevertheless, a threefold connection with these procedures, and should have a threefold interest in them.

In the first place, inasmuch as they are procedures applied to the sick and the study of disease, it is to be expected of the nurse that she will know of their existence and have some appreciation of their rationale.

In the second place, she will frequently be associated with the minutiæ pertaining to the collection of the specimen in such a fashion that the ensuing determination shall not be vitiated by technical errors in the collection of the blood.

Lastly, she should have sufficient knowledge of the subject to suspect when such examinations are to be made and to anticipate to some extent the subsequent treatment which may follow.

As has already been said, under ordinary circumstances specimens for blood chemistry should always be taken in the fasting state. When such examinations are ordered, therefore, the nurse should see to it that her patient has had no food on the morning in question. Water may be taken as desired. It is sometimes useful, also, to know something of the general diet of the patient, especially in the case of diabetes and to a lesser extent in hypertension and nephritis.

Coma of uncertain etiology is always an indication for blood chemistry. Preparations for such determinations should always be in mind.

Blood-chemistry specimens may be taken in one of two ways, depending upon the extent of the laboratory investigations to be made. When only the determination of blood sugar is desired, sufficient blood may be secured from a finger prick. When more than this is to be done, venipuncture is required.

There will be required, therefore, the following:

1. A tourniquet (rubber bandage, or the cuff of a sphygomanometer).
2. 10 c.c. Luer syringe sterilized by *dry* heat. If the syringe is sterilized by boiling or by chemical solutions, these must be thoroughly rinsed out with sterile saline and the syringe thoroughly dried.
3. A 22–20 gauge needle sterilized as described above.
4. Alcohol, cotton, and collodion to cleanse the skin and seal the puncture.
5. A tube in which to place the specimen. Because these must contain an anticoagulant in a definite quantity (potassium oxalate—2 to 4 drops of 10 per cent solution to 10 c.c. of blood, or 5 mgms. of a mixture of 10 parts of sodium fluoride and 2 parts of thymol for each centimeter of blood), these prepared tubes will usually be brought by the laboratory worker.

It is essential to remember that the blood and the anticoagulant must be *thoroughly* mixed as soon as the blood is placed in the tube. This is best done not by shaking the tube violently, but by inverting it ten or twelve times.

Needless to say, the specimen should be accompanied by the name and location of the patient, the examinations required, and the name of the doctor to whom the report is to be made.

Given a case of coma in which, trauma being ruled out, the diagnostic possibilities are diabetes or nephritis, what may the nurse prepare for, pending the return of the chemical reports?

In diabetic coma there are, of course, two things of vital importance to have at hand: insulin and sterile 25 per cent glucose solution, together with the necessary apparatus for intravenous administration. It is useful, and saves time as well as bulk of dosage, to have the insulin in

concentrated form, as large doses may be required.

In the nephritis case, elimination being the paramount initial issue, the following probable measures should be thought of and arrangements made to put those called for into play with the least possible delay:

1. Venesection.
2. Intravenous saline.
3. Hot packs.
4. Drastic purges by mouth (croton oil).

With these thoughts in mind the nurse may await the laboratory reports with a clear conscience, knowing that if there is undue delay in the institution of appropriate treatment it will not be because of dereliction, carelessness, or lack of understanding on her part.

Artificial Light as an Aid to Surgery

ARTIFICIAL light as an aid to surgery is discussed in a paper by Henry L. Logan, Illuminating Engineer of New York, appearing in the current issue of the *Transactions*, the official publication of the Illuminating Engineering Society. Mr Logan begins by dismissing the practicability of using daylight solely in the operating room, basing his objection on the uncontrollable features of natural light.

"If a bright spot of light is thrown on the operating area, leaving the rest of the room in comparative darkness," he says, "eye adaptation difficulties develop. The surgeon cannot keep his eyes glued to the small bright field throughout the operation. He has to ask for sponges, sutures and instruments. He has to give instructions. Things have to be moved. Every time he lifts his eyes from the bright field their adaptation changes and their sensitivity drops.

"The doctor makes special efforts, although perhaps unconsciously, to force his eyes to their work, but nothing he can do will increase the rate of recovery and his work meanwhile slows up in speed and reduces in accuracy, as what his muscles do depends upon how fast and clearly his eyes can see.

"Investigation has led to the conclusion that the ideal operating room light should be extremely flexible with a light pattern that can be varied with the types of operations performed. By controlling certain lights of the lamp system independently and publishing a switching chart of light patterns this last requirement from the engineering standpoint is fully met. The medical staff, however, should add one very necessary refinement—the use of a neutral-colored body cover to confine the high illumination to the wound area, by absorption of the overflow.

"It is the custom in hospitals to place a notice on the wall or door of the operating room one day in advance of operations to be performed. Along with this notice should be the light pattern switching chart. When the nurse goes to the chart and notices, for example, an appendectomy listed, she would glance at the light pattern chart and see certain switch numbers listed against that type of operation, and she would arrange the lighting accordingly."

The full discussion may be obtained by applying to the Illuminating Engineering Society, 29 West 39th Street, New York City.—*New England Journal of Medicine*, Boston, Mass., May 2, 1920.

Obscure Dental Sepsis

TO the onlooker in medicine few things have been more impressive in recent times than the awakening of medical interest in dental and tonsillar sepsis as factors in obscure systemic infection. That there has been a gradual change of attitude on the part of the family medical attendant towards his patients' teeth will scarcely be denied. How many doctors, fifteen years ago, thought of toxic absorption from a tooth socket when treating a case of sciatica or of unexplained pyrexia? In the early days of enlightenment pyorrhœa alveolaris was thought to be of prime importance; now it is apical sepsis that holds the centre of the stage, and the pulpless tooth—the "filled dead tooth"—is increasingly recognized as a menace to health. Bit by bit the evidence has been sought for, and pieced together, incriminating hidden dental sepsis as (to say the least) a predisposing cause of general disease. The fruits of the pioneer work of Dr. William Hunter have thus in the course of a few years become a commonplace of medical practice. . . . *Brit. M. J.*, 1920, I, 1020.—*The Medical Times*, New York, May, 1920.

Transfusion

By Means of the Scannell Apparatus

JAMES J. O'HEARN, M.D., and MINNIE STRUBE, R.N.

ALL blood transfusions are done in the operating rooms, under regular operating-room technic, unless the condition of the patient is such that he cannot be moved from the ward. This article covers ward procedure only.

The treatment, blood transfusion, is given by the physicians. Three are preferred, although two frequently care for the treatment. Two doctors are aseptically clean and the third checks on the blood pressure.

If three doctors are present, one nurse can give all the nursing care necessary during the operation, except in the case of a very restless patient. However, it facilitates matters greatly to have three help in the preparation, as follows:

1. The first nurse sets up the room, getting ready supplies, solutions, etc.
2. The second nurse cares for the patients, getting their arms into the proper position and making them comfortable.
3. The third nurse prepares and gives the hypodermic and assists the physicians and other nurses as needed.

The donor can hold the hand or wrist of the recipient if necessary, except in the case of very restless patients.

Definition

Transfusion is the passing of blood from one person to another without exposure of the blood to the air.

Purpose

To supply with blood any person suffering from extensive shock, primary or secondary anemia, or following hemorrhage even in the absence of shock.

Equipment

Articles for venesection:
- Scalpel
- Scissors
- Mosquito forceps
- Hemostats
- Skin suture needles
- Aneurysm needles
- Catgut, size 00.

Other articles:

Non-sterile—
- Sphygmomanometer
- Arm-board
- Rubber sheet
- Surgical cart for donor
- Rubber constrictor
- Iodine 3½ per cent
- Alcohol 95 per cent

Sterile—
- Gown
- Gloves
- Mask
- Sheet
- Towels
- Dressings
- Applicators
- Small basin
- Vaseline
- Novocain, 1 per cent solution.
- Sodium citrate, .25 per cent solution.
- Scannell Transfusion Set, consists in
  - 2 Wim Emerald syringes with bayonet locks
  - 3 tubes made of catheter tubing, glass finished inside, and supplied with Wim locks at either end to lock to the valve or to the needle
  - 1 valve which is a three-way unit, readily controlled by a small lever which can be manipulated by the left thumb, and is connected to the syringe by means of the bayonet lock and to the tubes by means of the Wim locks.

Needles are provided in several sizes. A needle devised by Dr. Raymond McNealy has a metal clip with small holes in it so that the needle

Operation, 1920

may be fixed to the skin by means of a sterile hypodermic needle.

Procedure

Treat the patient as in shock during the course of the procedure, watching for reaction at this time and later.

1. Place donor on a surgical cart at a convenient angle for the surgeon.
2. Arrange the arm-board at a convenient site for arm of recipient.
3. Cover arm-board with rubber sheet and with sterile sheet.
4. Place the arm of recipient on the arm-board.
5. The rubber constrictor is placed by the doctor aiding in giving the transfusion, around the upper portion of the arm.
6. Paint field with iodine 3½ per cent, followed by alcohol 95 per cent.
7. Drape with sterile towels.
8. Dip the piston of the syringe in warm sterile vaseline and work up and down. The excess of vaseline may be washed off with saline solution, 90 F.
9. Connect the apparatus, the tube with the sinker being placed in the middle. A small basin of normal salt solution is used and the air is expelled from the tubes and valves by filling them with this solution.
10. Pump the sphygmomanometer on the donor's arm up to about 60 m.m.
11. Inject novocain sol. 1 per cent into the skin over the most prominent vein and insert the McNealy needle into the vein, pointing it toward the hand. It is essential to get a free flow of blood from this needle, and the apparatus is not connected until it is obtained.
12. Then connect the side tube from the valve with this needle and inject about 10 c.c. of Ringer's solution, or normal salt solution, into the vein of the donor to make sure that the needle rests wholly within the vein. Release the sphygmomanometer.
13. Treat the arm of the recipient in a similar manner, with the exception that, in this case, the needle in the vein points toward the shoulder. The constrictor is then released.
14. Grasp the syringe in the left hand in such a manner that the valve may be controlled by the thumb. The valve is pointed toward the donor inlet and slowly filled.
15. Shift the valve next to point toward the recipient outlet and force the blood slowly out.

Caution

This procedure is repeated until the desired amount of blood is transfused. After 150 to 200 c.c. are given, it is usually found that the syringe begins to clog. It is advisable at this point either to shift syringes or to wash the syringe by drawing normal salt solution through the middle tube which is connected with the basin of salt solution.

If it becomes necessary, for any reason, to stop during the course of the transfusion, the constrictor on the arm of the donor is released and the apparatus is filled with normal salt solution.

For the best results the sphygmomanometer should register between 60 and 70 m.m., but this will vary with individuals.

At the end of the procedure the apparatus must be carefully cleansed, first with water, then hydrogen peroxide, then again water, and lastly ether.

Income Tax

IN reply to your letter (of May 16, 1929) you are advised that where competent evidence is furnished that (1) the taxpayer actually attended the conventions mentioned, (2) was not reimbursed by any individual, society, or organization for expenses incident to such attendance, and (3) actually expended for the purposes described the amounts claimed as deductions, it is held that the expenses incurred in attending the nursing conventions in question constitute proper deductions in computing the taxpayer's net income for the year or years affected.—Commissioner, Treasury Department, Washington, D. C.

Prepare Now for the Sunset Years[1]

The Harmon Annuity Plan

JAMES I. CODDINGTON

LIFE holds no richer reward than the satisfaction which comes to the teacher, the preacher, or the nurse who, in old age, looks back on a life of human service in which financial gain has not been the driving power or aim. But satisfaction will not pay bills.

Nurses, like others, grow old. As age increases, earnings tend to decline. Some day work must stop. Legacies and ordinary bank savings are too often spent before the later years of life, a time when needed most, for then it is usually too late for the nurse to return to work and to re-accumulate funds to replace those lost or spent. It is not safe or wise to count too much on relatives for financial aid. This is the experience of many former nurses, both married and single.

Even nurses who have, or expect to have, family help toward the financing of the long years ahead, find a *guaranteed* monthly annuity income of their very own, something to be very highly valued and a most welcome addition to other resources. To other nurses, it means complete freedom from all investment worries and the absolute certainty that, month after month, they will receive by mail a monthly annuity income check, right up to the last month of life. In the form of this income annuity check, the postman brings added happiness and a degree of financial security to the nurse's home; her declining years will never be without funds.

The Annuity Plan finally developed after several years of study, with the assistance of the special committee which was appointed by the joint boards of the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing, provides a simple but certain, businesslike, and scientific way for any registered nurse, regardless of where she works or lives, to build up an annuity fund through small and convenient monthly deposits or, if she already has accumulated funds which are not at present invested so as to carry the important guarantee of an annuity, to invest them through the Plan, so as to eliminate investment risks or worries, and to secure a definite and *guaranteed* income.

Of the ways one can invest a "retirement" fund there is only one certain way, so as to assure a *guaranteed*, definite and equal division of the fund over one's lifetime for one's own use, and that way is through annuities guaranteed by an insurance company authorized by law to issue and guarantee annuities. The nurses participating in the nurses' group annuity plan of the Harmon Association will always have the guaranteed annuity certificate of a leading insurance company approved by the members, and the Association will be always under the direction of trustees and officers selected by the members themselves. Of the ways of *building up* a "retirement" fund there is no way more secure than the convenient monthly deposit system of that Association. Your deposits, as they are made, are invested for you in guaranteed annuities, which month after month build up the size of your future annuity

[1] Prepared for the annual meeting of the North Carolina State Nurses' Association, August, 1929.

income until the time when you desire to cease making your deposits and to draw your income; thereafter the income annuity checks come in to you regularly by mail each month right up to the very last month of your life. Because the Plan of that Association is a group annuity plan, annuity payments to members may be considerably increased over and above the contractual amounts by additional annuity payments to members that may result from excess earnings in the administration of this Group Plan or from surplus funds of the Association arising from any other source.

Only *registered* nurses are eligible for membership in the nurses' group annuity system of the "Harmon Plan" which carries special features and options, some of which are unique and not to be found in the group annuity plans of the other social professions or in the ordinary type of annuity.

Among the more important features of the Plan are:

1. A permanent monthly income for your own use, which, once begun, continues throughout the remainder of your life, regardless of how long you live.

2. No medical examination.

3. Convenience to you in accumulating your fund and in your receipt of monthly income checks.

4. No loss to you or forfeiture of any of your deposits. No "surrender charge."

5. Absolute safety for your investment.

6. In case of any emergency, the privilege of borrowing against or of withdrawing all of your deposits at any time that you may wish, previous to the beginning of the annuity payments to you.

7. In case of your death, the immediate cash payment to your beneficiary of the full credit balance on your deposits.

8. An organization through which funds from legacies, endowments, gifts, excess interest, or other sources may be administered for your benefit.

9. Membership in an association organized to assist registered nurses, guided by your own trustees and officers chosen by the members themselves.

As is the case in all investment plans, the sooner you start, the more time you will have to build up the size of your annuity through small and the more convenient monthly deposits. Deposits may be made as small as $5 monthly and in larger monthly amounts in multiples of $5, according to the size of the annuity income you wish to develop, and your particular circumstances.

A pamphlet has been issued, entitled "Annuities for Nurses," which briefly but fully describes the plan. Copies of this pamphlet as well as enrollment cards can be secured by writing the Secretary of the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, New York City.

The government of the association is in the hands of a Board of Trustees elected by the members of the association. The trustees, under the constitution and by-laws, can receive no financial compensation for their services. The nature of the association has enlisted the cooperation of trustees who are connected with some of the most outstanding financial organizations in America, experts in law, banking, life insurance and annuities, as well as hospital and nursing organization executives, and the leaders in several of the largest organizations for social service in the country.

Your cooperation with the trustees of the plan in bringing it to the attention of other registered nurses will be appreciated.

American Nurses Complete Fund for Memorial School in France

CLARA D. NOYES, R.N.

WHILE the great Congress of the International Council of Nurses was in full swing, word reached the Chairman of the American Nurses' Advisory Committee of the Florence Nightingale School at Bordeaux, that the fund had "gone over the top," thus fulfilling the hope as well as the expectation of the Committee that the campaign would be completed in time to make the announcement at the Congress of the International Council of Nurses which convened in Montreal on July 8, 1929.

Fortunately, two graduates of the Florence Nightingale School at Bordeaux were present at the Congress, Mlle. Hervey and Mlle. Rossignol. The former is Director of a most interesting piece of Public Health Nursing in Rouen, the latter is now on a scholarship in this country. These earnest young women, together with a few members of the Advisory Committee and the Board of Directors of the American Nurses' Association, and others who had worked together to make the campaign a success, gathered around a luncheon table in Montreal. It was a dramatic moment when the announcement was made that the fund was completed. Through the minds of each one present there must have passed in retrospection a review of the years of patient and devoted effort on the part of Dr. Anna Hamilton, now in failing health, to establish a good system of nursing in France, also a vision of those American nurses who "in line of duty" gave their lives

THE SCHOOL AWAITING COMPLETION!

FRACTURE CASE

Students are not only taught modern methods but they are carefully supervised in their nursing practice.

to the great cause of right over might, and in whose honor American nurses have built this Memorial School. They must have thought also of the earnest and self-sacrificing work of the American nurses who, in many unique ways, sought to complete the fund and provide the missing wing, without which, like a crippled, wingless bird, the school could not entirely fulfill its mission. Brief speeches of presentation were made by the President of the American Nurses' Association and others, the French nurses, with their usual charm, responding.

Quietly, but diligently, the nurses of the United States through alumnae district and state associations and individually, worked to make up the state quotas, and they did it. They did it so well that many states went well over the top. Consequently, instead of securing the specified amount required to build the unfinished wing, a tidy little sum, over and above that amount, which might serve as the nucleus for an endowment, is in the hands of the American Nurses' Association.

The Advisory Committee which is composed of the following members, Clara D. Noyes, Chairman; S. Lillian Clayton, Ex-officio; Mrs. Jean Celhay; Anna C. Jammé; Elsie M. Lawler; Mrs. Chas. W. Shartle; Nina D. Gage; Ada B. McCleery; Mary K. Nelson; Evelyn Walker and Katherine Tucker, is deeply grateful to the nurses of the United States, not only for their individual generosity, but also for the splendid spirit of coöperation and devotion which they have manifested.

In reply to a cablegram of announcement sent to Dr. Hamilton, one in return was received from her and Monsieur Faure, the President of the Board of Trustees. Later the following letter was received from the President:

Miss Clara D. Noyes, Chairman,
Advisory Committee, American Nurses' Memorial, Washington, D. C.

Madam:

You have no doubt received the cable I sent you as soon as yours reached Doctor Hamilton, to thank you and all the American nurses for collecting the fund to finish the Memorial.

The last wing of the school will thus be built and more students will be enabled to receive the proper technical education.

We wish to express our heartfelt gratitude for the help your Association has thus given to the cause of nursing in France and the welfare of the French population.

You can rely upon us to do our utmost to see that the Memorial dedicated by you to the American nurses who died during the Great War may work and develop for the benefit of all concerned.

With our renewed thanks, we remain, Madam,

Yours respectfully,
(Signed) M. Faure.

The promise made by Monsieur Faure, in his letter, to maintain standards goes far to reassure the American nurses who have contributed so generously to this fund. That this useful and dignified Memorial will be maintained on a basis that will make it a fitting one to those who have made the supreme sacrifice, satisfies the hopes and desires of American nurses.

As some years have intervened

since the original gift was made, many of the older nurses may have forgotten, or the younger ones may never have known, that provision has been made in the constitution and by-laws governing the school, for a "Consultative Committee" composed of American nurses, which shall act in an advisory capacity to the school. A further provision has been made by the school authorities to safeguard the standards whereby

The school will always be directed by a hospital nurse, who shall herself hold a first-class diploma preferably from this school.

It will thus be seen that the authorities of the school have very carefully safeguarded the ideals and standards which are regarded by the American nurse as essential to a good school of nursing.

Since this provision was made, an American Advisory Committee representing the three national nursing associations has been maintained. This Committee has kept in close touch with the School, many members of which have made visits to the institution. In 1927, the President of the American Nurses' Association, Miss Clayton, accompanied by the Secretary of the Association, Miss Francis; Miss Lawler from the Johns Hopkins School of Nursing; Miss Eldredge, a member of the Board of Directors of the American Nurses' Association; and the Chairman of the Advisory Committee, who is also a Director of the same organization, made short visits to the institution.

The curriculum was carefully studied by Miss Eldredge as well as the others and each one felt that it compared very favorably with the best schools in the United States, and in some particulars was slightly more advanced. After a visit to the hospital

Milk Station, Florence Nightingale School, Bordeaux

where the practical work of the nurses was reviewed and where every evidence of thoroughness was observed, the members of the Committee felt that the American nurses had every reason to be satisfied with the character of the work that was being done, as well as the right to feel proud of the type of Memorial which they had erected.

It is the hope of the Advisory Committee as well as of the authorities at the school that American nurses who are visiting France will make a special effort to go to Bordeaux and see the School for themselves. They will be graciously received and will enjoy using the beautiful room with its priceless old furniture which has been set apart for the reception of American nurses.

Danger

FORBID him, if you think necessary, riding a bicycle on a street dangerous with traffic, but at least let him climb a tree. If we try to eliminate all danger situations, we make life stale, flat and unprofitable for the child. Better an occasional bruise than an intact mollycoddle; if the child has spirit, he will evade our prohibitions, taking his adventures surreptitiously, since he cannot have them with his parents' knowledge and consent. —From "Parents and the Pre-School Child," p. 212, Wm. E. Blatz. Publisher: Morrow & Co.

An Endowed Bed

How One Hospital Cares for Its Graduate Nurses During Illness

BEATRICE M. CLUTCH, R.N.

PROVIDING graduate nurses with hospital care in time of illness has always been a great problem and, according to the monthly reports from the American Nurses' Association Relief Fund, it so continues.

The Blessing Hospital School of Nursing of Quincy, Illinois, has about two hundred and twenty-five graduates and an Alumnae Association of about one hundred members. The problem of caring for them during illness has been worrisome for many years. Hospitals, as a general rule, do not give free care to graduate nurses unless there is some form of endowment. If no endowment is provided for them it is sometimes necessary for nurses to be considered on the charity basis. No nurse appreciates that kind of arrangement, even though no mention is made of the financial problem.

Two years ago, when Blessing Hospital was building a new addition, the members of the Alumnae Association desired to endow a room, wherein its members might receive free care during illness. To this end they pledged $7,500, which the hospital set as the lowest possible amount for the endowment. Each nurse who desired to do so pledged $120, to be paid in quarterly payments of $15 each for a period of two years. This is in effect a form of insurance, as nurses not pledging are not eligible for care under this endowment. In cases of prolonged illness the hospital expense may be for more than the amount pledged.

The entire sum has now been paid, and the Association has its own room nicely furnished. Last year twenty nurses received free care; the time varied from two days to six weeks.

Because of the demand for the room, and since the endowment has now been proven a success from the standpoint of the Association, it has started a campaign for a second room on the same basis. The nurses are now anxious for the opportunity to help with the endowment. The last two graduating classes have been 100 per cent in pledges, as they have seen the advantages of the plan.

We believe that if more hospitals would allow a similar "reasonable endowment," nurses would recover from illness more quickly and be ready for duty sooner, and surely it would mean less expense to the nurse. In the end, the Relief Fund would not be called upon to do almost impossible things.

From a Private Duty Nurse to a Registrar

"GEE, Miss C., isn't it a 'grand and glorious' feeling when you get out—free, white and 21. Hospital days were wonderful days but it's such a different feeling when you get out on your own. You can give so much more to your patient, do so much more—not only for the patient but for the relatives. Why, there are just a million little things to do, a thousand things to say! Why, even the way you look affects the entire family, doesn't it? Those girls can talk about the hospital all they want to, but give me home care!"

Talk Your Speech

MAY AYRES BURGESS,

WHEN we have speeches to make, let's talk them. Patients may like to be read aloud to, but audiences do not; and since talking the speech is one of the easiest of all technics, those of us who want to make a pleasant impression upon the people who have to listen to us would do well to learn it.

It is not necessary for a nurse to be an experienced public speaker in order to keep her audience awake. Neither is it necessary for her to memorize what she is going to say. Skilled speakers ordinarily leave their manuscripts at home and depend upon a single page of notes to guide them, but even this is not necessary to good speaking.

After she has prepared her manuscript and made sure that it says exactly what she wants to say, in just the way she wants to say it, the nurse speaker can, with a little practice, take the full manuscript to the platform and present it paragraph by paragraph without her audience being really aware that she has it with her. She can *talk* directly from her manuscript.

This is done by taking the finished manuscript home and trying to talk it through once or twice, noting meanwhile which words or phrases seem most helpful in reminding her what comes next. She will find in every paragraph one or more such phrases, which her eye catches as she looks down the page. When she finds these phrases, the next step is to take a ruler and a soft pencil and underline each one. In the box accompanying this article, the left hand column shows the opening paragraphs of a speech prepared in manuscript, with the key phrases underlined. In the column

As Written	*As Talked*
Madam Chairman and Members of the State Association: During the past year the Third District Graduate Nurses' Association has held eight meetings. We have an active Program Committee which prepared in advance a careful program for the year. The plan divided the year into two terms of four months each. The first meeting of each term was devoted to the discussion of nursing subjects with clinical demonstrations or lectures; the second to [illegible] problems as suggested by the findings of the Grading Committee; the third to possible solutions for these problems as suggested by speakers at conventions, etc. The fourth meeting of the term took the form of a Journal Party. The first three meetings stress the joint interests of the [illegible], but the fourth meeting of each term [illegible] in District membership. A final gala meeting is held, at which time the new class is admitted.	Madam Chairman, and Fellow Members: I am glad to report that during the past year we nurses of the Third District have held eight meetings, that is, one each month. We are fortunate in having an exceptionally intelligent Program Committee which takes charge of everything. The Committee divides the year into two terms, each term having four meetings. That is, September, October, November, December, are one term, while January, February, March, April, are the second term. The first meeting of each term is spent in studying some new nursing subject. For example, last September we had a discussion of the care of burns, with nursing demonstrations, and a talk by one of our physicians. The second meeting of each term this year has been spent in discussing the Grading Committee findings, and the meeting following that to a discussion of how we are going to find solutions for the questions the Grading studies raise. The proceedings of recent conventions are eagerly combed for suggestions. The last monthly meeting of each term takes the form of a *Journal Party*, and let me say here that the Journal parties have developed keen rivalry among the Alumnae and students of our local schools. Senior students are especially invited to these parties, and we give a prize to the school which [illegible]. The reception of the new class into the Association was one of the outstanding events of Commencement Week.

to the right is the same speech as the nurse actually talks it, using her manuscript for a guide.

To practice her speech, the nurse finds an empty room with a table. She stands behind the table and lays the manuscript upon it. She does not lean over to read the manuscript. She stands erect and pretends that there is an audience in front of her. Having given her opening salutation, she runs the first finger of her left hand down the page until it rests under the first key phrase. Then she starts talking her speech, using whatever words come easily to mind in order to state the thought suggested by that first key phrase. So she goes on through the whole speech. By running her finger down the pages from one underlined phrase to another, she keeps her place and is relieved from all necessity for memorizing. With a little practice she can talk her speech in a normal voice and with simple, every-day language which audiences love, and she need neither be afraid of leaving out important points nor of putting in too much additional comment, since her left hand is checking up all the time and showing her the path she wants to follow.

In the illustration, note that the speech as actually talked and which is reported in the right hand column contains many additional phrases or sentences which amplify the thought as the nurse first presented it in her written manuscript. This will almost always happen, and it is these running comments which help to make a speech human. If the nurse has not had a good deal of experience in public speaking, and if she attempts to talk, either without any manuscript or with brief notes, she runs the risk of adding too many extra comments and so confusing her hearers or running over her time. If, however, she is careful to follow the key phrases in her original manuscript as she talks, she can add a good many explanatory sentences and yet will always be reminded of her main outline so that she is not apt to go far astray.

Talking a speech is courteous. Suppose any of us had a visitor seeking our help on some vital matter. How would we like it if, when he presented his case, he kept his head down, his eyes lowered, and in a high, artificial voice read aloud from a prepared manuscript the arguments with which he sought to move us? Wouldn't we be inclined to interrupt rather curtly with "Look me in the eye and tell me plainly what you want!"

The reason, let us hope, that we give a speech at all is because we want to help our audience or we want to persuade it to help us. It is the audience to which we should pay attention and not the tight, little wording of our manuscripts. If the nurse has a real thought to present, the device of underlining her key phrases and following them with her finger will keep her on the right track and she need not worry about the words she will use. Her ordinary language will do well enough.

She should worry a little, of course, about the sort of voice she will use in getting her speech over. There are four tricks of the trade which are open to anyone who wants to try them. The first may be stated as, *Keep your chin up!* If her chin is raised just a little higher than usual, so that it makes a firm, smooth line without a suggestion of a wrinkle, it gives the effect of being mentally on tiptoe. Her words will be flung out eagerly to the audience, instead of being dropped into the manuscript or on the floor at her feet. She will find herself fairly leaning forward, as though to close the gap between the

speaker's platform and those rows of listening people. She can't mumble her manuscript if she keeps her chin up.

The second rule is, *Talk to the back row!* If the back row can hear us, the front row surely can. Eagerly, and with chin up, it pays to talk directly to the nurses who sit near the back of the room. Most of them are there either because they came in late or because they want to leave early. In either case they do not expect to be particularly interested in what we have to say. The fun of the game is to go after that back row. Make them interested. Don't let them leave early. If the speaker can make her voice so clear and impelling that it stirs up everyone in that outer fringe, she will sometimes discover that her whole audience is alert, and working with her.

The third rule is, *Throw your voice out!* Sometimes we are surprised to find that a little woman can out-talk a big man. She can be heard all over the hall, whereas the man, whose tones are far deeper and more resonant, may not be audible beyond the third row. In such cases the trouble with the man usually is that he swallows his own words. They go down his throat or up his nose, instead of coming out of his mouth. Probably most women ought to try to speak in a little deeper tone than they usually use, but even comparatively thin and high voices can be clearly heard if the speaker learns to talk with the front of her mouth and not the back of it. Teachers of voice give elaborate exercises for teaching how to do this; but almost anyone, probably, can make her voice more audible by a little home practice. Go into an empty room (because you are going to make horrible faces, and won't want to be laughed at) and say your speech all the way through—opening your mouth as wide as you can on every word, and making your lips exaggerate every motion. A little daily practice of that sort will soon teach you where the front of your mouth is, and while you won't make faces when actually giving your speech, you will at least be more proficient in throwing your voice out where it ought to go.

Finally, every speaker needs to learn, *Make your words clean cut!* In a hall where there is any echo, a speaker who runs her words together becomes very difficult to hear. The nurse who proclaims "Mam Chemun: Iyavethe onsof repseningthe membusuvthe Thirdistrit" isn't going to help the reputation of the Third District. If she will cut those twenty-two syllables clearly, so that each one is given its true value, she will in all probability notice a little stir of interest run through her audience, even at that stereotyped beginning. Speakers who pronounce each word crisply and clearly are so rare that audiences love them, and if an audience likes the speaker, it is apt to like what the speaker says.

Anyone who addresses busy people, owes them the courtesy, first, of talking to them, not reading at them; and second, of talking so they can understand what she says. If she ducks her head, mumbles her words, and concentrates upon her manuscript, the audience may surely be excused for paying little attention to the sounds which issue rather queerly from her throat. The courteous speaker is the one who, first, thinks carefully just what she wants to say; second, prepares the manuscript so that she knows just how to say it, and third, practices methods of presentation so that when finally she stands upon the speaker's platform she can obey the mandate: *Look your audience in the eye and tell them plainly what you want.*

For the Patient's Book

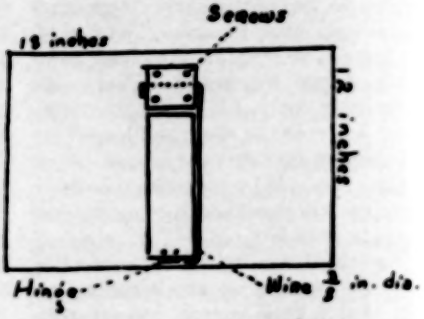
MARY A. ROSSMAN, R.N.

IN response to a request in the July *Journal*, I submit drawings of a device in successful use. It is light in weight and adapted for use on bed, bedside table or on the patient's lap when he is sitting up.

The inexpensive and easily procured material required is:

1 board, 18 x 12 x ⅝ inches.
1 board, 18 x 1⅛ x ⅝ inches.
1 board, 11 x 3 x ⅝ inches.
1 hinge.
8 screws.
1 wire, ⅜ diameter, length 15 inches.
1 wire, 1/16 inches diameter, length 12 inches.

Side view when open for use.



Plan view when folded.

½ in. shelf; extending 1½ ins.

Wire 12 x 1/16 inches.

Wire twisted into shape and flattened. Is used to secure pages in open book.

Nursing by Religious Orders in the United States

Part IV—Lutheran Deaconesses, 1849-1928

ANN DOYLE, R.N.

"The Lord giveth the Word:
The women that publish the tidings are a great host."
—Psalms LXVIII: 11.

ON July 14, 1849,[1] Pastor Theodor Fliedner arrived in Pittsburgh from Kaiserswerth bringing with him four Deaconesses to take charge of the Pittsburgh Infirmary.[2] This is the first date when Deaconesses, as nurses, assumed charge of a hospital in the United States.

"The first mention of Deaconesses in the United States is in connection with the Lutheran Church and comes from Kaiserswerth. In Pastor Fliedner's annual report, January 1, 1847, he says; 'We have been urgently requested to send Deaconesses from here to N. America to take charge of a hospital and organize a motherhouse. The American clergyman who personally made the request laid the matter upon our conscience with such urgency that we could but promise to send out a number of sisters as soon as it should be possible!'"[3]

The "American clergyman" referred to was the Rev. William A. Passavant, whose name will be forever connected with the inception and beginnings of Deaconess work in America.

At his request, in 1849, Pastor Fliedner came with four Deaconesses to take charge of the hospital which Dr. Passavant had founded in Pittsburgh, the first Protestant Church Hospital in the United States.

[1] The date of Pastor Fliedner's arrival has been variously placed from July 14 to July 17. The date chosen for this paper has been taken from the Yearbook of the United Lutheran Church in America, 1920, p. 12.

[2] Now Passavant Hospital.

[3] Wheeler, Rev. Henry, "Deaconesses Ancient and Modern," chap. xiv, p. 284.

SISTER LOUISA MARTHENS

First American Deaconess to join Kaiserswerth Deaconesses at Pittsburgh, 1850

"This new establishment was begun as a station of the Kaiserswerth Motherhouse, though it was clearly understood from the beginning that at the earliest possible date it should become independent, and be conducted as a Deaconess Motherhouse for the education and training of Sisters in America. With this end in view, 'The Institution of Protestant Deaconesses of the County of Allegheny' was incorporated in 1850 under the laws of the Commonwealth of Pennsylvania."[4] The charter reads:

[4] Fritschel, Rev. Herm. L., "A Brief History of the Lutheran Deaconess Motherhouses in America," p. 32.

FIRST PROTESTANT HOSPITAL IN AMERICA, 1849, NOW THE PASSAVANT HOSPITAL, PITTSBURGH, PA.

"The objects of this Institution shall be:"

The relief of the sick and insane, the care of the orphan, the education of youth and the exercise of mercy to the unfortunate and destitute.

The four Deaconesses who came with Pastor Fliedner; namely, Elizabeth Hupperts, Pauline Ludwig, Elizabeth Hess, and Louisa Hendrickson together with Louisa Marthens are named in the articles of incorporation. Under this corporation most of the institutions of mercy founded by Dr. Passavant have been conducted, although a regularly constituted Motherhouse was not fully realized until 1893 at Milwaukee, Wis.

The founding of Pittsburgh Infirmary was an attempt on the part of Dr. Passavant to meet the needs of the sick poor of his community, there being no hospital in the vicinity to which they could be taken from their wretched homes.[5] The inspiration came to him while in London, in 1846, attending the first general conference of the Christian Alliance, whither he had been sent as a delegate. During this visit in Germany he became acquainted with Pastor Fliedner and Pastor Haerter, the two Deaconess fathers. Pastor Fliedner invited him to visit Kaiserswerth. The practical service of the Deaconess ministry profoundly impressed his soul, and at once he planned to transplant the Deaconesses and their ministry into this country.[6] He discussed his plans with Pastor Fliedner who, as is well known, was always ready with encouragement and help, and deposited with him, provisionally, money for traveling expenses of the Sisters whom he hoped to obtain.[7]

Upon his return to this country, Dr. Passavant set about to awaken interest and understanding in the work and to take steps toward procuring a hospital to be ready for the sister nurses, whose arrival he prayed for daily. "In the spring of 1848 he

[5] For information concerning the social, economic and industrial conditions of this period, see the *Journal*, August, 1929, pp. 959, 960, 961.

[6] Fritschel, H. L., *op. cit.*, p. 32.

[7] Mergner, Sister Julie. The Deaconess and Her Work, p. 69.

rented a house in Allegheny, at the foot of Montgomery's Hill, for his Deaconess Hospital. True, the Deaconesses had not yet arrived but his heart was so full of the new project that he could not wait. . . . His judicious mother chided him for his undue haste in renting a house, soliciting fine furniture for the reception room and making all arrangements before the experienced Deaconesses had come. In her judgment the Sisters would know more about what was needed and how to make the arrangements . . . at the same time the mother sent him a *large bed* (italics ours) for the new hospital."[8]

The first patients to be admitted to the new hospital were two soldiers returned from the Mexican War, ill of ship fever. With the aid of Asa Waters, a divinity student, Dr. Passavant went to the docks, found two men ill in their bunks, took them from the ship and loaded them into a carriage. "The reception room was furnished and ready. The kitchen had a cook stove and table. One nurse's room had been fitted up. The sick rooms had one bed and several chairs. Several cots and bedding were hastily ordered from the store, and so the patients, the embryo outfit and the two men started for the empty house. . . ."[9] Dr. Passavant and Mr. Waters nursed the men with their own hands because nurses could not be procured.

This experience, and the cholera epidemic which visited this region about that time, proved this house not to be adaptable to hospital purposes, and Dr. Passavant was advised to find quarters more suitable. A new property was found, beautifully situated on the crest of a hill overlooking the river valleys, and was purchased for $5,000. The new hospital had forty beds.

Two years had elapsed, however, before the promise of Pastor Fliedner could be fulfilled. In his annual report of 1848, he expresses regret in thus far not being able to fulfill his promise: "We had expected to send out Deaconesses to N. America this spring, but thus far we have been unable to do it." But in January, 1849, the announcement is made: "God willing, in the course of the summer four Deaconesses will start for Pittsburgh, N. A., to assist in the organisation of a Motherhouse."[10]

While awaiting the coming of the Deaconesses from Kaiserswerth, Dr. Passavant's wife acted as the matron of the new hospital and assisting her was Louisa Marthens, who was consecrated a Deaconess May 28, 1850, one year following their arrival, thus becoming the first American Deaconess.[11]

Pastor Fliedner makes mention of these facts in his report of 1850: "In N. A. thus far, no Deaconesses were to be found, but a great number of Roman Catholic Sisters of Mercy. Now the Rev. Dr. Passavant, an English Lutheran pastor of Pittsburgh, Pennsylvania, has established a hospital since we promised to send out Deaconesses for the nursing of the sick and the training of American probationers. In the month of June, 1849, the inspector (Fliedner himself) had the pleasure of accompanying four Sisters in their journey to Pittsburgh, Pennsylvania. About the middle of July they took charge of the newly established hospital, and immediately afterwards they received the first American probationer."[12]

[8] Garberding, G. H., "*Life and Letters of W. A. Passavant, D.D.*," 3rd. ed., p. 184.
[9] *Ibid.*

[10] Wheeler, *op. cit.*, p. 234.
[11] Morgner, Sister Julia, *op. cit.*, p. 70.
[12] Wheeler, H., *op. cit.*, p. 236.

In 1851, another Deaconess was sent from Kaiserswerth and three German immigrant girls entered as probationers."

The progress made did not fulfill the promise of the beginning. Within five years from the opening of the institution three of the four Deaconesses from Kaiserswerth had quitted the work and another who had come in 1857 returned to her home in 1858. In thirty-five years, from 1849 to 1884, only sixteen candidates entered the Pittsburgh institute with a view to becoming Deaconesses. Their training was chiefly practical. Several were consecrated Sisters but nearly all, for various reasons, terminated their affiliation in from one to five years."

"The church was not ready for the work when introduced by Dr. Passavant, but the few Deaconesses of his institute did most efficient service, especially in cholera epidemics, during the Civil War, and in starting and administering the numerous institutions which he was called upon to undertake."[13]

Among the Deaconesses who remained were Sister Elizabeth Hupperts, Sister Louisa Marthens, Sister Barbara Kaag, and Sister Caroline Ochse. These saintly women and a few others kept alive the Deaconess ideal and, although their number was few, to their credit must be placed many of the good works cited by Dr. Jacobs. The hospitals at Milwaukee, Wisconsin, Chicago, and Jacksonville, Illinois, owe their existence to these unselfish Sisters.

When the Civil War broke out, Dr. Passavant offered the services of the Deaconesses and probationers to Miss Dix to enable her to organize and train groups of nurses for service. Their work in the army received unstinted praise from Miss Dix. In 1861, she wrote Dr. Passavant:

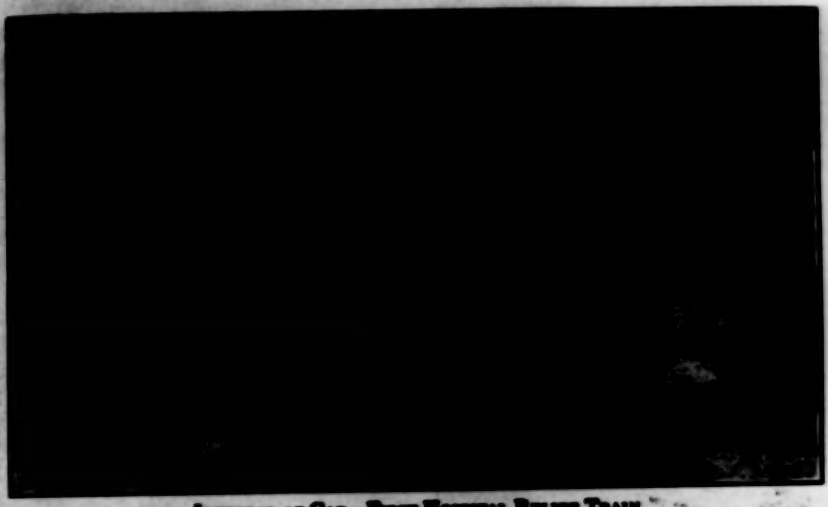
> Dear Sir: I may not have the evidence to go by to show the value I have placed on the services rendered by Sister Elizabeth and the other Sisters in their beloved Christian duty. Although we would like to see the end of this unhappy war, it is my purpose to have a substantial evidence made of my appreciation of our friends and their toil in the cause of humanity. Yours Cordially, D. L. Dix. December 28, 1861, Washington.

And again: I have your valued letter. I had already written after my return from the Fortress to Sister Elizabeth, stating my appreciation of her services, and of the great sacrifice she has made in the cause in leaving her charge so long. I thank you for your hearty cooperation and Christian sacrifice you have made to the great work in lending your choice hospital force to the hospital service they have rendered and this under serious difficulties. I hope Sister Elizabeth received my letter. I shall, if life be spared, give a more solid evidence of my appreciation of her devotion to an arduous and hard work. Please present my cordial regard to her. (No date.)[14]

Milwaukee Hospital was founded in 1863. Sister Barbara Kaag was called home from war service to open it. Many letters passed between Dr. Passavant and Miss Dix before the Sisters were finally released. All of the Sisters at the Milwaukee Hospital were trained nurses, that is, in the meaning of the term at that time: Sister Caroline Ochse was trained at Kaiserswerth; Sister Martha Genslke, who succeeded Sister Barbara, in 1885, as Superior, was trained by Sister Barbara; and Sister Katharine Foerster who joined the group in 1868, had spent some time at Neuendettelsau.

Thirty-five years after the first Deaconesses came to America, a second and successful attempt was made to transplant the Deaconess

[12] Wheeler, H., *op. cit.*, p. 208.
[13] Friedel, H. L., *op. cit.*, p. 32.
[14] Jacobs, H. E., "A History of the Evangelical Lutheran Church in the United States," p. 267.
[15] Gutsending, G. H., *op. cit.*, p. 218.



INTERIOR OF CAR—FIRST HOSPITAL RELIEF TRAIN

Two hundred and seventy-five cases of typhoid were brought from Camp Meade, Middletown, Pa., to the German Hospital on special hospital trains at the expense of the hospital.

come to this country. At the request of the Board of Directors of the German Hospital,[17] Philadelphia, seven Sisters came from the City Hospital, Iserlohn, Westphalia, to take charge of the nursing work.

The German Hospital was organized by a group of benevolent citizens who felt that the German-speaking patients would be happier and receive more satisfactory treatment if they could express themselves to physicians and nurses in their native tongue. The first attempt was made in 1850 and a second attempt in 1853, but both of these failed. Finally, in 1866, their efforts were proven fruitful when the legislature of the state of Pennsylvania passed an act incorporating "The German Hospital of Philadelphia." The object of the hospital was to receive and care for the sick and wounded without distinction as to nationality, creed, or color.

Arrangements for occupying the property were about completed when the United States Government which at that time, the beginning of the Civil War, was in great need of hospital facilities for the care of the sick and wounded soldiers, took possession of the same and occupied it from June 20, 1862, to the end of July, 1866, for a monthly rental of $125. In 1866, the Board again took control and opened it for the care of civil patients. Mr. John Lankenau became president of the Board in 1869.[18]

In 1883 the charter was changed and three pastors of the Evangelical Lutheran Ministerium of Pennsylvania were made members of the Board of Trustees; the idea of securing Deaconesses to take charge of the nursing of the hospital was discussed.

The attention of the Board now being directed to Deaconesses, Mr. Lankenau and Mr. Charles H. Meyer, German Consul of Philadelphia, began

[17] Now Lankenau Hospital.

[18] "History of the German Hospital," 1906, pp. 13–14.

SISTER MARIE KRUEGER

negotiations with the several German Motherhouses. Kaiserswerth and other places were visited but all efforts seemed in vain. Finally, the Rev. C. Ninck of Hamburg called their attention to a small independent group of Sisters in Iserlohn, who might possibly be in position to accede to their wishes. An agreement was reached and the Sisters started for Philadelphia.

On June 19, 1884, Sister Marie Krueger, and her six companions arrived in New York; here they were met by Mr. Lankenau who took them to the Hospital, their future home. Sister Marie was trained at Kaiserswerth. The Sisters who accompanied her were Sister Friederike Wurzler, Sister Wilhelmina Dittmann, Sister Marianne Kraetzer, Sister Magdalene von Bracht, Sister Alma Kohlman, and Sister Pauline Loeschmann. Of the original group, Sister Magdalene, is the sole survivor.

Sister Marie died in 1887; she was succeeded by Sister Wanda von Oertzen. Sister Wanda was trained in nursing at Kiel and had worked with a Deaconess institution in Stettin. She was a great power for good for the little Philadelphia group.

Although the Sisters had many trials, they nevertheless had a staunch friend in Mr. Lankenau, and excellent support from the Board of Trustees, and in a short time had increased

SISTER ELISABETH
Who Started Norwegian Lutheran Deaconess Home and Hospital

their numbers and had organized several other pieces of work, among which were the Children's Hospital, Easton Hospital, St. John's Hospital, Allegheny, Pa., and the Kensington Dispensary for the treatment of tuberculosis.[10]

Sister Elisabeth Fedde, a trained

[10] Archives of the Philadelphia Motherhouse.

nurse and a trained pharmacist, from Louisenberg, Oslo, Norway, was the first Deaconess nurse to labor among the Norwegian sick poor in the United States. She came to Brooklyn, April 19, 1883, through the interest and help of Anna Börs, wife of the Norwegian Consul-General, and the Reverend Mortensen, Pastor of the Norwegian Seamen's Church in Brooklyn.

For a year and a half after her arrival Sister Elizabeth worked as a visiting nurse going from house to house nursing the sick and helping those who were in need. Finally, a Deaconess Home and Hospital was opened in a rented house at 441 Fourth Avenue. It contained nine beds. Two probationers had joined Sister Elizabeth.

The rented quarters soon became inadequate and in 1889, the Sisters and their supporters set about building a new hospital. Two lots were bought on the corner of Fourth Avenue and 46th Street, Bay Ridge, the present location of the hospital.

Bay Ridge was then to a great extent unsettled territory. Horse cars traveled only as far as 25th Street. Beyond that was the country. The Sisters moved into the new hospital in October, 1889, and the first patients were received in December. The new hospital had thirty beds. As the hospital work grew, it was extended beyond the care of Norwegians and became a community hospital in fact. The Sisters in Brooklyn have always devoted themselves to the care of the sick entirely.

Of the earlier Sisters, two, Sister Dorothea and Sister Karen, belonged to the Norwegian Deaconess Home in Christiania. They had been lent to the struggling American group and when that was on its feet they were recalled to Norway. While Sister Elizabeth was in Minneapolis, Sister Dorothea took charge of the Brooklyn Hospital.[29]

In the great Norwegian center of the Northwest, where the Norwegian Lutheran Church has developed so rapidly, we find the second Norwegian Deaconess Hospital springing into being. In 1888, Sister Elizabeth and a probationer began their work of ministering to the sick in the city of Minneapolis from a rented flat. Under Sister Elizabeth's wise guidance the work grew and progressed until it became necessary to provide hospital space. This was done, and on September 1, 1891, Sister Ingeborg Sponland became the Directing Sister of the new institution at 15th Avenue and East 23rd Street.[30]

The Deaconess work of the Swedish Lutheran Church in America owes its existence to the devoted labors of Pastor Fogelstrom. In 1887 he sent Sister Bothilda Swensen to Philadelphia to be trained and a year later four other probationers followed her for a like purpose. After spending an additional year in Stockholm, Sister Bothilda returned to Omaha to begin the work which has grown so magnificently there. Here she remained until 1898, when she assumed charge of the Bethesda Hospital, St. Paul, Minnesota.

The work at the Bethesda Hospital was really the work of the sisters from Omaha. As early as 1880 the Minnesota Conference of the Swedish Lutheran Augustana Synod had agitated the establishment of a hospital, and a few years later opened one at the city of St. Paul. But owing to the lack of properly trained personnel it had to be closed and remained closed for nine years. On March 8, 1892, the new Bethesda Hospital was opened. Sisters from the Motherhouse in Omaha

[29] Archives of the Brooklyn Motherhouse.
[30] Pritzlaff, H. L., *op. cit.*, p. 46.

SISTER ELISABETH HVIDTFELDT
First Lutheran Deaconess in America

were engaged to take charge of it. Four years later, 1896, the hospital was enlarged to the capacity of sixty beds. A training school for lay nurses was organized in 1901. This school was under the supervision of the Sisters for several years.

The third Norwegian Lutheran Deaconess Hospital was founded in Chicago at Haddon Avenue and Leavitt Street, in 1897, after several unsuccessful attempts had been made.

In 1891 three Sisters from the Norwegian Lutheran Deaconess Institute at Minneapolis began the work in Chicago. In the fall of the same year a hospital was opened and conducted until 1893, when it was destroyed by fire.

After some difficulties caused by dissensions among committees, a new property was purchased, and the Sisters, in spite of all the handicaps and discouragements, went to work caring for the sick. Sister Marie Larsen took charge of the new building in place of Sister Ingeborg Oberg, who had resigned because of ill health.

Under the care of this group of Sisters come the following hospitals: Bethesda Hospital, Crookston, Minnesota; Deaconess Hospital, Grafton, North Dakota; Deaconess Hospital, Northwood, North Dakota; St. Luke's Hospital, Fergus Falls, Minnesota; St. Luke's Hospital, Fargo, North Dakota; Ebenezer Hospital, Madison, Minnesota; St. Olaf Hospital, Austin, Minnesota.[28]

The youngest of the American Deaconess Hospitals was founded at Brush, Colorado, for the treatment of tuberculosis patients in 1905. Sister Marie Hvidtfjeld was sent to Denmark for training, and two other Sisters were sent to the Motherhouse at Omaha. They returned in the fall of 1905 and entered upon their work in Eben-Ezer.[29]

Despite the fact that practically all of the early Deaconesses in the United States, beginning with the first group from Kaiserswerth, were nurses, very little is known of the nursing methods used by them, and this little has not been written down. This, no doubt, has been due to the fact that they, in common with all pioneers, gave little thought to making a permanent record of their work. There is, however, evidence all along the line to show that the older Sisters trained the younger ones in the new technics as they were developed, and that staff doctors held classes for the Sisters before the hospitals were opened for the training of lay nurses.

The first Lutheran Deaconess Hospital to organize a school for lay nurses seems to have been Lankenau in Philadelphia. This school was opened

[28] Fjelstad, H. L., *op. cit.*, p. 49.
[29] *Ibid.*, p. 49.

in 1899, with Sister Marie Koeneke, the present Superintendent of Nurses, in charge. The Forty-first Annual Report of the Hospital states:

> At present, ten young women are being trained in the Hospital, under the direction of the Sisters, and under the theoretical instruction of the Medical Staff of the Dispensary. . . . The younger Sisters participate in this instruction. These young women, during working hours, wear a uniform, and it is intended to give a suitable diploma to those who pass a satisfactory examination at the end of their tuition.[24]

The first course was for two years and after that it was lengthened to three years. The members of the first class were Eva Peterson, Bertha Knoll, and Virginia Mosher. The names of the Sister nurses of this class are not known.

Since 1899 practically all of the Deaconesses' hospitals have organized schools of nursing. In many instances they have Sister superintendents of nurses. All of the schools have lay nurses as instructors, supervisors, and the like, attached to their staffs.

On September 16, 1895, the first conference of the Evangelical Lutheran Motherhouses in the United States was held in Philadelphia. Representatives from Philadelphia, Omaha, Minneapolis, and Milwaukee met at the Mary Drexel Home for a three-day conference.

These conferences, which have been held biennially, have been productive of much good. As in the case of other religious groups, these Sisters have other charitable and social institutions under their care besides nursing—the care of the aged, the orphan, the delinquent—and much of the time of the conference is devoted to these as well as the spiritual development of the Sisters themselves. Nevertheless, nursing has a prominent place at all of the meetings; for nursing is a primary function of the Deaconess and every one, no matter what her future work is to be, is given some training in the care of the sick. Those, of course, who are to take charge of hospitals or become superintendents of nurses are given a complete training and postgraduate work. Several Sisters from the different Motherhouses have been to Teachers College, Columbia University. A sister from the Philadelphia Motherhouse is at Temple University at the present time.

As early as the third conference, Dr. Passavant read a paper on "The Deaconess and the Trained Nurse" in which he outlined the great opportunities which are open to the Deaconess as a trained nurse but stressed the point that she must be trained.[25]

At the fourth conference, Dr. Fritschel, in a paper entitled "The Aim and Limits of Deaconess Work in Hospitals," not only makes the same point but goes into detail as to why training is needed and why those who undertake the care of the sick are obligated to provide them with skilled nursing care. To Dr. Fritschel, probably more than to any other modern pastor, is due the credit for the great professional advances made by the Deaconess nurse. "She is not a physician," he writes, "and does not assume the responsibility of a physician upon herself; of her no one must expect what may be expected of a skilled physician. Her duty and responsibility lie in carrying out the instructions of the attending physician and nursing the patient." And for her preparation to do this he gently points the way.[26]

[24] Forty-first Annual Report of the Trustees of the Germans (Lutheran) Hospital, 1901, p. 27.

[25] Passavant, W. A., "The Deaconess and the Trained Nurse," Proceedings of Third Annual Conference, Omaha, 1899, p. 15–21.

[26] Fritschel, H. L., "The Aim and Limits of Deaconess Work in Hospitals," Proceedings of the Fourth Annual Conference, Baltimore, 1903, pp. 6–10.

By 1910, the Deaconesses' hospitals had been open to the training of lay nurses sufficiently long to cause the Rev. H. B. Kildahl to raise the question: "Is it advisable to train nurses along with Deaconesses? If so, how may the true Deaconess spirit be maintained?" Dr. Kildahl did not think it was and said so most emphatically, but the majority present did not subscribe to his opinions.

The twelfth report makes reference to the fact that six Sisters are working as district nurses. This, no doubt, is the work of the Parish Sisters of which there are several in New York, New Jersey, and several other states.

At the thirteenth conference, the first Sister nurse reads a paper. She is Sister Grace Lauer of Philadelphia, and her topic is "Special Training for Special Service." Thus speaks the modern daughter of Kaiserswerth:

> This is the age of specialization. Specialization is staring us in the face at every turn and there is no possibility of escape. Efficiency, the password of the twentieth century, is more sought after and when found, more prized than ever before. If we would keep step with progress, we must mentally depart from the old-time idea that natural ability may, without development, be directed into any convenient channel. . . . We must "covet earnestly the best gifts."[17]

The Deaconesses who have become trained nurses, in the modern sense of the term, have taken their places in the ranks of the profession and assumed their obligations with their lay nurse sisters. When registration came to the various and several states in which they were working, they were among the first to become licensed. For example, Sister Esther Porter was the first Deaconess registered in Minnesota; Sister Emma Lerch in Milwaukee. The Deaconesses in Pennsylvania were among the first nurses to be registered in that state. Sister Esther Porter served on the Board of Nurse Examiners in Minnesota, and was sometime Training School Inspector in that state.[18]

Similarly, Deaconesses have joined the local, state and national nursing associations, and have contributed their share toward building and maintaining high standards for our profession. It has been difficult to tell to what degree the Deaconesses

[17] Lauer, Sister Grace, "Special Training for Special Service," Proceedings of the Thirteenth Annual Conference, St. Paul, 1915, pp. 49–52.

[18] From data collected by questionnaire sent out by the *Journal*, January, 1920.

have participated in the development of local educational work, for like other nurse religious they are modest and retiring, very often refusing to allow their names to be mentioned in connection with committee work and the like.

Several Deaconess nurse educators are members of the National League of Nursing Education. Among these are Sister Olive Cullenberg, Omaha; Sister Mathilde Gravdahl, Brooklyn; Sister Marie Koeneke and Sister Edith M. Bube, Philadelphia; Sister Elfrida Herzog and Sister Emma Lerch of Milwaukee. Thus four of the ten Motherhouses are represented. For years Sister Esther Porter was one of the very few nurse religious members of the National League of Nursing Education.

Sister Esther Porter died November 1, 1926. The Bethesda Hospital Alumnae Association has raised a fund with which they are going to furnish a room in her memory in the new nurses' home which is presently to be built.

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Medical Education in the United States

THE Constitution of the United States made no provision for federal control over education but left such matters to the police powers of the several states. With a few exceptions, these did not establish supervision over the chartering of educational institutions. As a result, medical schools multiplied much more rapidly than the increase in population required. By 1900, the United States had 160 medical colleges, or about one-half the world's supply.

In the absence of legal control, the function of regulating medical education naturally rested with that portion of the public in the best position to recognize what should be done—the medical profession through its national body, the American Medical Association. Following its organization in 1847, through several investigations on separate occasions, the deplorable conditions in medical education were reported and resolutions adopted suggesting improvements. With the reorganization of the American Medical Association in 1902, a House of Delegates was created to look after the business affairs and general policies of the association. Among its first acts the House of Delegates appointed several standing committees or councils, one of which, the Council on Medical Education, was instructed to work directly for improvements in medical education. The Council began a series of annual conferences at which standards of both preliminary and medical education were presented and given discussion. During the college year of 1906–07, an inspection of all medical schools was completed and the Council's first classification of medical schools was prepared. From the beginning of its work, the Council had cooperation from the deans of all the better medical schools. The improvements made were both rapid and remarkable. When two or more institutions were found in each of a score or more cities, the inspectors urged that these schools merge, thereby forming a single but better equipped institution. In this way the number of medical schools was gradually reduced until now, instead of 160, only 76 recognized medical schools remain. From the beginning of its work the Council has received hearty cooperation from the medical schools and medical profession of Canada. It is noteworthy that in this, the twenty-fifth year of the Council's work, all medical schools, both in the United States and Canada, have completed the essential improvements whereby the Class A rating has been given.

It should be clearly understood that the work of improving medical education in the United States was initiated by the organized medical profession in an effort to "put its house in order." Following the completion of its first inspection of medical schools, in 1907, and in order to secure the widest possible publicity regarding the needs of medical education, the Council appealed to the president of the Carnegie Foundation for the Advancement of Teaching that a special investigation be made by that organization. During the session of 1909–1910, therefore, a second tour of inspection was made jointly by Abraham Flexner and the Secretary of the Council, which resulted in the notable report of 1910. It will be recalled, however, that the foundation made no classification of medical schools nor did it suggest any standards, these matters being continued as the work of the Council on Medical Education and Hospitals.—*From an Editorial, Journal of the American Medical Association, August 17, 1929.*

Endoscopy

A Description of the Technics Used at the Chevalier Jackson Bronchoscopic Clinics, Philadelphia

NORA L. ZUFALL, R.N.

ENDOSCOPY, as the name implies, is looking into the cavities of the body by means of an endoscope or speculum. These specula vary in appearance and make-up as they vary in use. We are concerned chiefly with the air and food passages, therefore we will consider only the "scopes" most practical for inspecting these parts of the body, namely:

The laryngoscope—for looking into the larynx.
The bronchoscope—for looking into the trachea and bronchi.
The esophagoscope—for looking into the esophagus.
The gastroscope—for looking into the stomach.

Preparation of Patient for Endoscopy.—Before an endoscopy is done there are certain routine studies which should be made. The patient should have a complete medical examination, including a blood Wassermann. If there are any contra-indications to an endoscopy, they should be discovered before the endoscopy rather than during it. A careful Roentgen-ray examination should be made of the neck, chest, and swallowing function. In the case of a suspected foreign body, the Roentgen-ray examination should include the area from the upper neck to the ischia. If only the usual chest examination is made, the foreign body may be missed entirely, as it may be either above or below the area examined. Every peroral endoscopy should be preceded by a mirror laryngoscopy.

The patient should have nothing by mouth for at least five hours before the endoscopy. If no anesthetic, or only a local anesthetic, is used, as is the case in the Chevalier Jackson Bronchoscopic Clinics, adults are usually given a hypodermic injection of morphine and atropine sulphate. As this is given chiefly to lessen reflexes, it should be given about an hour and a half before operation.

When the patient is brought to the operating room, with him should be his temperature chart, an emesis basin, and gauze. Glasses and all artificial dentures should be removed. Any patient who has been given morphine directly preceding the endoscopy should be brought to the operating room on a litter, even though he may be an ambulatory case.

Position of the Patient During Peroral Endoscopy.—The position of the patient during peroral endoscopy is very important. The patient's head is brought over the end of the table so that the center of the scapula rests on the end of the table. The head is held by an assistant who sits at the patient's right. His arm is brought under the patient's neck in such a way that he can put the bite block, which is on the middle finger of his right hand, in the left corner of the patient's mouth. His left hand is then used to support the patient's head. The patient should be sufficiently relaxed for the one who is holding the head to be able to move it to whatever position is desired. The shoulders should be kept flat on the table. Whether the patient's head be held high or low, to the right or to the left, the position of the shoulders should not change. The patient's hands should be kept at his side. In a patient who has to be

controlled, the hands held at the side will help to keep the hips straight on the table, and give one better control of the patient. In foreign-body cases it is particularly necessary that the patient be kept from moving, as a movement on his part may strip the foreign body from the forceps. Unless the patient is in the correct position, peroral endoscopy is almost impossible.

After-care.—In all endoscopic cases requiring hospitalization, there is certain routine after-care. The patient is returned from the operating room to his bed and usually remains there for a few hours, at least; longer if his condition indicates it. The patient should be watched most carefully for any signs of dyspnea. Should any develop, the condition should be reported immediately. The patient's life frequently depends on the early recognition of dyspnea. Always remember that cyanosis is a dangerously late symptom of dyspnea. Whether the operation be a laryngoscopy, a bronchoscopy, an esophagoscopy, or a peroral gastroscopy, dyspnea may follow.

Direct Laryngoscopy

DIRECT LARYNGOSCOPY is an examination of the larynx with the aid of a laryngoscope.

Indications.—The most common indications for a direct examination of the larynx are hoarseness and dyspnea. While no nurse is ever called upon to make a diagnosis, every nurse should be familiar with symptoms, and the treatment of the conditions to which these symptoms are due. Hoarseness may be due to:

1. Irritation of the larynx.
2. Irritation of the vocal cords.
3. Growth in the larynx.
4. Growth on the vocal cords.
5. Foreign body in the larynx or trachea.

Irritation of the Larynx.—Irritation of the larynx may be due to an acute inflammation, such as is caused by the common cold or some other acute infection. This will usually clear up as the patient's condition improves, and in this condition a direct laryngoscopy would not be indicated. If the irritation and hoarseness continue for an unusual length of time, a direct examination would be indicated. If the irritation is due to over-use, or improper use, of the voice, rest of the larynx is usually all that is required. In cases of tuberculosis of the larynx, absolute rest is required, the patient not being permitted even to whisper. All his communications should be in writing. The general care is that given to any tuberculous patient: rest, fresh air, proper diet, et cetera.

Irritation of the Vocal Cords.—Irritation of the vocal cords is usually due to over-use. One may talk too much or talk in such a way that the cords become strained. As this condition is brought about by improper use of the voice, the usual treatment is vocal rest. The patient is sometimes permitted to whisper when it is necessary, though more often absolute rest is required.

Growth in the Larynx.—A growth in the larynx may be either benign or malignant, and for that reason persistent hoarseness should not be neglected, but an early diagnosis insisted upon. This diagnosis can best be made by a direct examination and biopsy. As it is usually a very small piece of tissue that is removed, great care should be taken in transferring it from the forceps to a small sterile container. The specimen is sent to the laboratory in whatever solution the histologist desires. If the growth proves to be malignant, a laryngofissure with excision of the growth, or a laryngectomy may be advisable. If the extent of the growth makes surgery inadvisable, the patient is usually treated by radiotherapy.

Position of Patient, Assistant and Nurse for the Introduction of the Bronchoscope and Esophagoscope

From page 1032, "Ear, Nose and Throat," Jackson, Coates (W. B. Saunders Co., Publishers).

Papilloma of the larynx is a fairly common condition and is usually treated by removal of the papillomata at frequent intervals until they cease to appear. This may be a matter of weeks, though it is often a matter of months or years. The papillomata frequently fill the larynx so completely

that a tracheotomy is necessary. After the papillomata have ceased to recur, the patient is decannulated and usually has no further trouble.

Growth on the Vocal Cords.—A growth on the vocal cords, as well as in the larynx, may be either benign or malignant, and should be diagnosed in the same way. If the growth proves to be malignant, excision is usually indicated. If it is benign, it is usually removed through the laryngoscope by means of cupped forceps. A benign growth on the vocal cords is generally due to over-use or improper use of the voice. Nature's way of protecting an over-used part is to cause thicker tissue to grow there. As every abnormal condition is best treated by removing the cause, a benign growth on the cord is usually treated by removing the growth through the direct laryngoscope, then enforcing vocal rest. While one vocal nodule is not a predisposing factor, the conditions which caused the first one may cause subsequent ones.

Foreign Body in the Larynx or Trachea.—Symptoms of foreign body in the larynx or trachea are dependent upon the type, size, shape and location of the foreign body. A foreign body can probably best be defined as any substance which is foreign to that particular location; for example, food, which would not be a foreign body in a normal esophagus or stomach, would be a foreign body in the air passages. At the present writing there have been over twenty-three hundred foreign bodies removed from the air and food passages of patients in the Chevalier Jackson Bronchoscopic Clinics. These foreign bodies include safety-pins, straight pins, nails, tacks, small toys, bones, hardware, ammunition, nut kernels, seeds, shells, coins, and many other articles which should never have been put in the mouth. A foreign body which is large enough to lodge in the larynx or trachea is usually large enough to cause some difficulty in breathing; therefore dyspnea, more or less marked, is one of the most common symptoms. If dyspnea develops suddenly, in an otherwise healthy individual, and particularly if it is preceded by an attack of coughing, choking, and gagging, the presence of a foreign body should always be suspected until ruled out by all possible means of diagnosis. A characteristic wheeze is usually present. The breathing in a case of foreign body in the larynx or trachea is so similar to the breathing in a case of laryngotracheal diphtheria that complete studies are necessary in order to make a correct diagnosis.

Laryngeal Dyspnea.—Laryngeal dyspnea is brought about by any condition which causes a smaller laryngeal lumen than that required for normal breathing. Dyspnea due to laryngeal or tracheal foreign body has already been discussed. Probably the most frequent cause of both acute and chronic dyspnea is diphtheria, although it may be brought about by other acute infections or trauma. Chronic stenosis may also be due to paralysis, faulty tracheotomy, or the wearing of ill-fitting tracheotomy tubes. In cases of acute laryngeal stenosis, a tracheotomy is often indicated.

Chronic laryngeal stenosis has been satisfactorily treated by dilating with metal bougies. This treatment is usually carried out perorally through the laryngoscope, although retrograde dilatation is used to advantage in some cases.

After-care.—After a direct laryngoscopy the patient should be put to bed and watched very closely for any signs of dyspnea. Although this complication is fairly rare, early

recognition of it is so imperative that the possibility of its occurrence must be kept in mind. The patient may be given crushed ice by mouth, and kept on liquid diet for the first twelve or twenty-four hours.

Bronchoscopy

BRONCHOSCOPY is the examination of the trachea and bronchi with the aid of a bronchoscope. The indications for bronchoscopy may be classed under four main headings, namely:

1. Foreign body in the trachea or bronchi.
2. Chronic cough.
3. Dyspnea.
4. Pneumonography.

Foreign Body in the Trachea or Bronchi.—One of three things may occur with a tracheal foreign body; it may be coughed out by the patient or removed with bronchoscopic forceps used through the bronchoscope; it may fill the trachea so completely that the patient becomes asphyxiated before aid can be obtained; it may pass through the trachea into the lung, this being the most common disposition.

The symptoms of a foreign body in the lung are dependent upon the size of the foreign body in relation to the size of the patient; the type and shape of the foreign body; the location of the foreign body in the lung; the length of time the foreign body has been in the lung. The initial symptoms of foreign body in the lung are choking, gagging, and coughing. If the foreign body is large enough to cause obstruction in one of the larger bronchi, these initial symptoms will be followed by dyspnea. If the foreign body is small, such as a pin or a tack, the initial symptoms will be followed by a symptomless interval. It is this symptomless interval which is so misleading and causes the history of foreign body to be disregarded, or initial symptoms forgotten, before further symptoms develop. It is for this reason that many chronic invalids are treated for years without a history of foreign body being elicited.

Contrary to common belief, organic foreign bodies are not absorbed, but usually set up a very violent reaction. Peanuts are one of the most dangerous foods or toys a child under two years of age can have. A child under that age cannot masticate peanuts, and when using them as a toy the peanut frequently finds its way into the child's lung. Here it sets up a very violent reaction and, in addition to the obstruction caused by the peanut, there is the obstruction caused by the swelling of the tissues as well. Death very frequently follows the inspiration of a piece of peanut in a very small child. Peanuts are probably the most common vegetable foreign body found in the lung.

Inorganic foreign bodies which are non-obstructing can sometimes remain in the lung for a very long period of time without causing any alarming symptoms, although in most cases an abscess will form within a few months. As this abscess is seldom associated with the choking which occurred some months previous, when the patient had a tack or some similar object in his mouth, this part of the history is not often given. When the abscess is forming the patient is usually quite ill. There is a rise in temperature, pulse, and respiration. If the foreign body is removed at this stage of the illness, complete recovery within a few days is to be expected. If, however, the foreign body is allowed to remain in the lung for a longer period of time, the patient develops many signs which have frequently led to an erroneous diagnosis

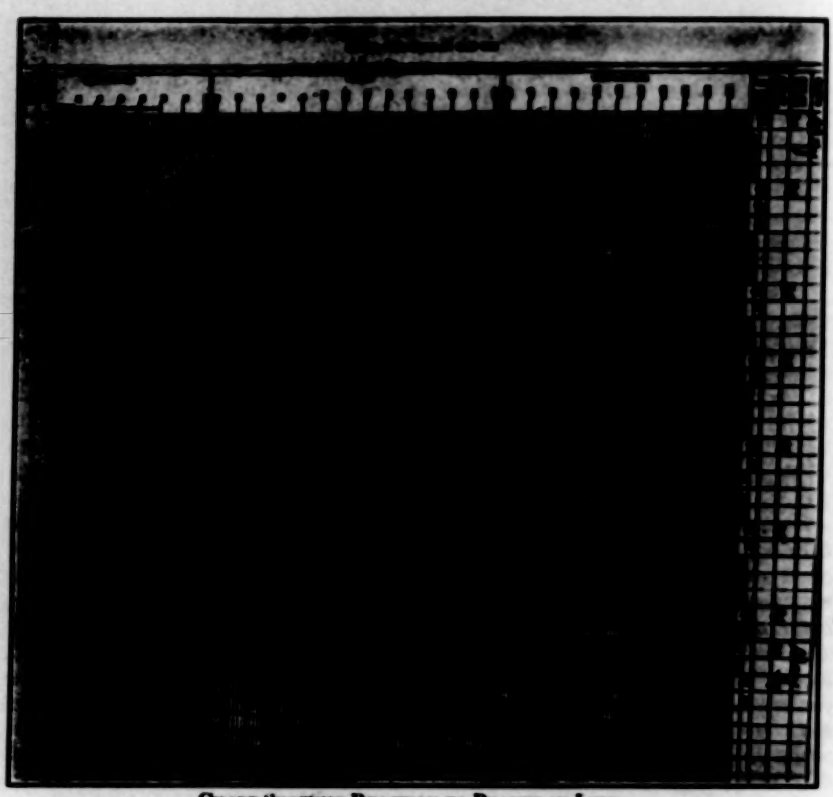


CHART SHOWING REACTION TO PEANUT IN LUNG

of pulmonary tuberculosis. The patient has a productive cough, is emaciated, has clubbing of the fingers and toes, tires easily, and has an evening rise in temperature. In a case of pulmonary abscess, tubercle bacilli are not found in the sputum, the apices of the lungs are clear and, if it be a metallic foreign body, Roentgen-ray examination will reveal the presence of the foreign body and the absence of any tuberculous lesion.

Most cases of pulmonary suppuration due to foreign body are cured by the removal of the foreign body, although in some few cases subsequent bronchoscopic aspiration may be necessary for a complete cure. Early bronchoscopic removal of a foreign body in the lung should be the rule. Unless removed, a foreign body which causes dyspnea will cause death in a short time. A foreign body which remains in the lung may cause weeks, months, or even years of suffering and invalidism, and eventually death.

Chronic Cough.—The bronchoscope is a valuable aid in diagnosing the cause of chronic cough. Chronic cough may be due to:

1. Pulmonary suppuration.
   A. bronchiectasis.
   B. lung abscess.
2. Pulmonary stilectasis.

3. Lung tumor.
4. Chronic tracheo-bronchitis.
5. Asthma.

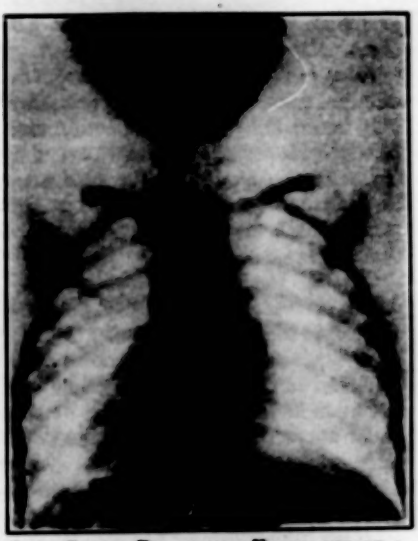
Pulmonary suppuration may be caused by any condition which prevents free drainage from the lung.

Bronchiectasis is the dilatation of the smaller bronchi.

Lung abscess is a localized area of pus in the lung.

As there is seldom free drainage in a case of pulmonary suppuration, bronchoscopic aspiration of pus may be necessary at rather frequent intervals, in some cases as often as twice a week. As the quantity of pus lessens and the patient's condition improves, the treatment is carried out at less frequent intervals. After the pus is aspirated, local applications of medication may be made through the bronchoscope. In addition to bronchoscopic aspirations, postural drainage is found to be quite beneficial. Two or three times a day the patient is encouraged to lean over the side of the bed and cough. This should be done for about fifteen minutes at a time, or until the patient has coughed out all the free pus possible. As this is a rather uncomfortable procedure, the patient may have to be reminded of the necessity for it. Postural drainage is effective only when the secretion is thin enough to flow, and when the opening from the infected area is large enough for the secretion to escape.

Pulmonary atelectasis is a condition brought about by an obstruction in the lung which prevents the entrance of air. This obstruction may be a foreign body which has been inspirated, but frequently it is found as a post-operative condition in general surgery. As a post-operative complication it is due to a very thick, tenacious secretion. The cough reflex is lessened by the use of opiates; therefore, instead of the secretions being coughed out as they form, they remain in the lung and may cause either a complete or partial obstruction. The air which was in the lung at the time the obstruction occurred is absorbed, and as no more air can enter, there is a collapse of the lung. In some cases, discontinuing the use of opiates and reëstablishing the cough reflex is all the treatment that is needed. In most cases, however, bronchoscopic aspiration of the secretion is necessary in order to "uncork" the lung. In these cases, attempted postural drainage is useless as the secretion is so very tenacious.



Open Safety-Pin in the Esophagus of a Child 5 Years Old

Safety-pin was removed through the mouth with the aid of an esophagoscope.

Post-tonsillectomic pulmonary abscesses are fairly common. As they usually develop a short time after the tonsillectomy, they are recognised early, and in most cases can be cured by bronchoscopic aspiration. It is to be remembered that not all pulmonary abscesses are cured by bronchoscopic

drainage; in some cases surgical excision is necessary.

Lung tumor may be either benign or malignant, but a definite diagnosis can only be made by direct inspection and possibly biopsy. Surgical excision is frequently indicated in the case of a benign tumor. In an advanced malignant growth in the lung, deep radiotherapy may be used.

Chronic trachea-bronchitis is being quite successfully treated by bronchoscopic aspiration.

Asthma may be due to a number of causes. In cases where the cause has not been definitely determined by the usual allergic tests, the bronchoscope may prove to be a very valuable aid in diagnosis. Dr. Chevalier Jackson states that "all is not asthma that wheezes," and bronchoscopic examination may find the true cause of the "wheeze."

Dyspnea to a more or less marked degree is associated with all the conditions already discussed under bronchoscopy.

Pneumonography is much more satisfactory, in many chest cases, if an opaque substance has been injected into the area to be examined. Through the bronchoscope, bismuth may be insufflated by the use of the Clerf bismuth insufflator. Lipiodol is probably used more frequently than bismuth at the present time. This may be instilled through the Tucker lipiodol instillation outfit which consists of

A 20 c.c. Luer syringe, a six-inch rubber connection tube, and straight and curved, spiral tipped, lipiodol tubes.

Immediately after the instillation of lipiodol or the insufflation of bismuth, the patient is sent to the x-ray room and should not cough until after the Roentgen-ray examination has been made.

(To be continued)

Who Are the Gold-Star Nurses?

1. Nurses are eligible to the gold star when they have had continuous membership on the registry for seven years.

2. The gold star nurses are privileged in that they may choose day or night work, hospital or home calls, and are not held to Regulation No. 1: "Nurses accept the use of the Registry with the understanding that they take day or night, hospital or outside calls."

3. They must observe all other regulations and must state, above their own signatures, the services they prefer and the services from which they wish to be excused.—From Detroit notes, The *Michigan Nurse*.

The Strength of Sweetness

SUGAR is one of the three great pillars of our dietetic temple—meat, sugar-starch and fat—and the greatest of the three; for, as has been said, all starches are turned into sugar in digestion, thus making the latter nearly two-thirds of our diet.

The crimes and delinquencies blamed upon sugar sinners down to chums that it "makes the teeth ache," and, if eaten just before a meal, it sometimes kills the appetite for that meal before sufficient calories have been absorbed. Also, its taste is so attractive that children may devour it in excess.

As a matter of fact sugar, in itself, never affects a clean, healthy tooth, though it will sometimes make a decayed one jump. And here sugar deserves a vote of thanks for warning the owner of the teeth that it needs skilled attention before it becomes so bad that it has to be extracted.

Both of the other supposed ill effects of sugar can be avoided by establishing a closed season for sugar and sweets, during which none may be taken, beginning one hour before the next meal. Moreover, if children are given liberal and intelligently balanced amounts of sugar at their meals, as dessert and in fruits, they will never develop that irrepressible, unreasonable craving for sweets.—Woods Hutchinson, M.D., in *Ladies' Home Journal*, March, 1920.

The Qualified Office Nurse

Her Preparation and Her Ethics

ELLA M. BOKHOF, R.N.

THERE are three types of office nurse. The first is better known as an office attendant. She is the gracious hostess of the doctor's reception room, welcoming his patients, caring for their comfort, keeping them happy while they wait their turn, knowing when an emergency case should receive his prompt attention and tactfully handling her part in notifying the doctor and holding the patience of those to whom the imperative need means a delay. She answers the telephone, keeps the office neat and attractive, and if the doctor desires, is also his stenographer and bookkeeper. Her work is largely in the outer office.

The second type may assist in the outer office but her work is mostly that for which the doctor has trained her. She is able and willing to do anything that might be required of an office attendant, and frequently does such work in the doctor's private office. She answers when the attendant in the outer office pushes the "buzzer" to the doctor's private telephone, and often she can care for such calls without taking his time. She cares for the sterilising of his instruments and other work of the operating room for which the doctor has trained her. She is a real nurse in his office, an assistant on whom he depends.

The third and highest type is the qualified office nurse. She has had hospital training and, ideally, is able to care for difficult cases with no more instructions from the doctor than he would usually give the registered nurse left in charge of a patient in a private home. She assists in operations performed at the office. She may be a nurse who has been through the rigorous experiences of hospital, government or private nursing, and appreciates the comparative ease in the life of the office nurse.

These types have characteristics in common. The office nurse, as well as any other woman in public life, has an influence on other lives. In her endeavors for a noble life, she will help those with whom she comes in contact. By being friendly, she will have friends. By being dependable, she will make herself indispensable to the doctor.

The efficient and qualified office nurse is not always the one who can accomplish the most work in an hour. She is the observant nurse who sees the needs of the doctor and saves his time and strength in countless little ways without his definite order, yet never for a moment overstepping her authority. But in case of emergency, she uses her intuition, knowing that she can rely on her own judgment on many occasions when the doctor is not present, because of her intimate knowledge of his wishes and of the details of his work. She knows the technical terms used in the lines in which the doctor is a specialist, and therefore understands his wishes with the fewest possible words from him. She is able and willing to do professional errands for him.

She arrives at the office at least five minutes before the appointed hour for duty, and is ready to greet the doctor with a cheery "Good morning." She is refined, quiet, courteous, maintaining her dignity in the presence of the doctor as well as when with his patients; yet she is inspiring, restful,

with a fine sense of humor which takes her over difficult situations with a smile while keeping a ready sympathy with all. Her dress, always of material easily laundered, is always immaculate, as is her person. She has the charm of good health and proper food and rest. She is quick in meeting and interviewing in succession all comers to the office, and in obtaining the name and other information desired by the doctor. She uses good grammar, gentle words, and pleasant manners, keeps an even temperament all day and every day, and has a tactful discretion as to when the doctor and his patient should be left entirely alone for private consultation. She is ever ready for the slightest call from the doctor, and shows her loyalty to him by her faithfulness. Should occasion arise, this loyalty leads her always to speak well of the doctor. She respects him, honors him, believes in him, always wishing for him the best of success and many friends.

She knows constantly where to reach the doctor quickly, if need arises, and how to have ready the appliances, such as bandages, disinfectants, and instruments likely to be needed when he arrives. In case of emergencies, she first calls the doctor, and while awaiting him she applies the best "first aid" of which she has knowledge, always careful to do nothing to injure if the case is beyond her experience and knowledge. A study of the doctor's library, in her moments of leisure while on duty in the office, and questions on subjects needing his explanation, are helpful in advancing her position as office nurse, care always being taken not to disturb the doctor when he is busy.

The characteristics, duties and relations of an office nurse are many and frequently exacting. In order to perform them most efficiently, her hours when not on office duty must be so arranged that she will have sufficient sleep and exercise, and be at all times physically, mentally and spiritually fit, otherwise she will be giving to her work less than her best.

Dr. J. Greig Smith, many years ago said:

> A perfect nurse is a perfect woman, rarely to be had; but there are possibilities of perfection, however, in every human being of average health and ability. Both men and women fail oftener in attaining a high degree of excellence in character and work, from indolence rather than incompetence.

A nurse cannot do her best when fatigued, worn in appearance, or worried. She must conserve her energies constructively, not permitting them to be wasted by yielding to temptations which undermine body or soul. She may improve her mind by reading only the best literature, by companioning only with those who are helpful to her or those whom she can help, never with those who can offer her only the allurements of supposed happiness which ends in disaster. Each human being is constantly fashioning his or her own body, mind and soul by thoughts and actions which can be directed toward improvement if the individual so desires. The office nurse, by her contented mind and cheerful disposition, shows that she considers her profession worth while.

One of the first requirements in a qualified nurse is personality, that something which distinguishes her from all others and is recognized the moment a person comes in contact with her. Every person has characteristics or habits which work for or against success and which frequently become automatic. Personality is inherited, but much of it is also developed or acquired through personal effort, self-denial and determination.

Each office nurse moulds her own destiny, to a certain extent. The process begins in early childhood and continues throughout life, consciously or unconsciously.

Some personalities are full of energy, will power and good character. These have an attraction which draws to them the things the person desires and is seeking, and they give out a helpful radiance of power which commands respect and inspires confidence. Beauty of face or form is but the outward expression of the life within, if the nurse is living up to her possibilities. The so-called homely person may and often does have a personality with such lasting goodness that she is a far greater success than the nurse whom heredity has favored more lavishly. It is possible for a pretty face to have back of it a mind of shallow thought and a life with no solid foundation. The qualified office nurse does not require cosmetics or showy dress to be attractive or successful.

The personality of the qualified office nurse is expressed in many little things with which she fills the moments between her regular and specified duties. She beautifies the office, by seeing that the pictures hang straight, that the calendars are up-to-date, the curtains tidy, the flowers fresh and the plants watered, and that there are not too many back numbers of papers and magazines on the reading table. She is willing to remove cobwebs around the electric lights if that has been neglected by the janitor, or to dust the furniture. She keeps all equipment brilliant with cleanliness, replenishes the little accessories, and prepares ample supplies in advance of the doctor's needs. She keeps the doctor's storeroom clean and in order. She keeps her own hands and breath antiseptically clean, but without the odor of disinfectants upon her person. Neither does she make conspicuous use of perfumes. She makes the entire office attractive with efficiency and the joy of service.

The well-qualified office nurse has intuitions by which she reads the patients who come to see the doctor. She is a keen student of human nature, and reads not only facial expressions and characteristics, but manner of walk and speech. She is tactful, patient, sympathetic but not too much so, cheerful yet dignified. Very nervous people are highly sensitive and can read faces more readily than others, and the office nurse should by her very presence give them confidence and hope. She is the representative of the doctor, while the patient waits for him. To that extent, she makes or mars the success of the visit. She may, probably does, say little; but her personality, reflected in herself and her surroundings, gives a feeling of pleasurable anticipation that holds the interest of the patient until the doctor himself can be seen.

Above all, she has a character above reproach, and a reputation unsullied. If she makes mistakes, she climbs over them by careful study never to do that thing again. She makes friends for the doctor and for herself, she keeps them. She rises constantly in her profession, because of her sincerity, justice, ability, and her trust in the God whose life permeates her own, and to whose leading she looks for guidance in the intricate details of her daily duty.

Two I. C. N. Committees

TWO of the obviously important committees of the International Council of Nursing are those on Public Health Nursing, Mary S. Gardner, Chairman; and Nursing Education, Isabel M. Stewart, Chairman. Full reports will appear in the Proceedings.

The report of the former appears in the current *Public Health Nurse*. It is summarized here because of its bearing on the whole question of nursing education. It is based on reports from twenty-four countries where the census of public health nurses varies from a few individuals, in Bulgaria, Iceland and Korea, to 1,200 in Holland; 10,000 in Great Britain and 12,000 in the United States of America.

According to the report, the preliminary education of these nurses is somewhat unsatisfactory. The United States is the only country where the completion of four years of high school is, in general, the aim. Belgium, Bulgaria and Cuba require some secondary education, the others build on primary education, although those with secondary education are preferred.

In Canada, Cuba and the United States, full training is required for public health nursing; in the Irish Free State, 99% are fully trained; in Belgium and Great Britain, 75%; New Zealand, 65%; Norway, 60%; Italy, 35%; Finland, 33%.

Canada and the United States have postgraduate courses. In Cuba, Finland, Great Britain, Holland, New Zealand and South Africa, courses of from two to twelve months have been organized.

In the United States, with its larger number of nurses, the percentage taking postgraduate courses is low; while in Finland it is high, 88%.

Education Committee[1]

THIS committee has nineteen active and ten corresponding members. Twenty-five countries were represented at one or more meetings of the committee in Montreal.

The report is presented under the headings:

I. Fundamentals in constructing a curriculum for nursing schools.
II. Duties and responsibilities of professional nurses.
III. Facilities and conditions essential for the establishment of a good school.
IV. Standards for admission to nursing schools.
V. The educational program.

In discussing fundamentals in constructing a curriculum, the report says: "Before presenting these results, it may be well to explain that the original idea was to outline a curriculum embodying *minimum* standards for nursing schools. As the discussion progressed, however, it became evident that a minimum which could be accepted for the less advanced countries might be a handicap rather than a help to the countries which had progressed beyond that stage." It seemed wise, therefore, to direct our efforts toward the outlining of an *optimum* rather than a minimum standard. "An optimum standard does not represent an impossible or impracticable ideal but rather those conditions which have been found to be most favorable to the normal, healthy development of nursing students under the conditions that exist in most of the countries represented in the I. C. N."

"Any curriculum should be a guide and not a law," and while the committee is opposed to a rigid or static curriculum, "we believe there are certain fundamental objectives which

[1] Excerpts, only, of the report are given here.

all progressive groups of nurses should be able to agree upon" and that the larger aims of nursing practice and nursing education should be kept before the profession.

Aims To Be Realized

1. To place nursing service and nursing education on full professional basis.
2. To bring the conception of nursing service to include nursing care of the whole patient, mind as well as body, attention to the whole environment, social as well as physical, prevention of sickness, etc.
3. This broader conception of nursing presupposes a more highly qualified type of nurse than the more routine type of nursing service.
4. It presupposes a higher level of educational work and a different type of educational process, etc.

Into an educational program to meet such aims should go:

1. Experience and subject matter, based on present and probable future needs of the student, for the practice of her profession and not primarily on the immediate needs of the hospital for getting work done.
2. Preparation of nurses to work in different types of communities, etc.
3. Basic course which gives good foundation for general practice and in the main fields.
4. Avoidance of waste in the basic preparation of the nurse.
5. Whatever is essential to the development of an all-round competent nurse.

The section on duties and responsibilities of professional nurses corresponds to the beliefs of the more thoughtful nurse educators in this country.

Facilities and Conditions Essential to the Establishment of a Good School for Nurses

These were amplified under the following headings:

A. Importance of a good teaching field.

B. Type of hospital to be selected for practical experience.

C. Capacity of hospital. "It is strongly advised that the minimum for establishing a hospital school should be placed not lower than 100 patients in the home hospital."

D. Variety of clinical service required for a basic training. "Committee recommends facilities for medical, surgical, children's, obstetrical nursing (as distinguished from midwifery) where possible, communicable disease nursing and mental and nervous; care of men and women; active operating service; especial facilities for diet kitchen, teaching diets."

E. Financial resources and arrangements. Committee believes budget essential and a budget distinguished from the hospital's budget for nursing service. Strongly advises that in making adjustments (financial) emphasis should be put on the fact that the young nurse is a student and not an employee. Nursing schools should be put on the same self-respecting economic basis as other forms of professional education. State and public authorities to realize responsibility for contributing to and maintaining nursing schools just as they do schools for teachers, etc.

F. Staffing. After excluding all nurses engaged in teaching, supervising, operating, out-patient work, etc., the committee believes that the ratio of one nurse to four or five patients is reasonable and practically essential during the hours when the ward is most active, a larger number of nurses

being assigned to pediatric, psychiatric and private wards. Most favorable conditions are where there is a suitable graduate staff of at least one head nurse or sister, one graduate staff nurse to each ward of 30 or 40 patients during the day and at least one graduate to every 100 patients at night. For a hospital as a whole, a ratio of graduate nurses to student nurses should be approximately 1 to 4.

G. Proportionate emphasis on housekeeping. Routine domestic work should not be required after the first six months at the latest.

H. Hours, vacations and night duty. The committee strongly recommends an 8-hour day, a 6-day week. Vacations should be at least one month, each year, not omitting the final year.

I. Housing and living. Residence should be separate from the hospital. Nurses should have the privacy and quiet of individual rooms.

J. Relation of school to hospital. Opinions vary. "Whatever these relationships may be there are two indispensable conditions: adequate financial support and freedom to develop the work of the school."

K. Organization. Whether an integral part of the hospital or separate foundation, the primary purpose of the school should be educational. It should have a training school committee. The functions of such a committee or board are to study needs of school as an educational institution, to see that it has the necessary staff, and to secure and authorize the expenditure of funds, etc.

L. The administrative and teaching staff of the school. Must combine the qualifications of executives and educators, must have experience and education along both lines in addition to their professional qualifications as nurses. Following offices are found:

1. Head of school, whatever her title, should have direct communication with the Board of the Hospital. Should submit regular reports.
2. The head should have usually two or more assistants, assistant matron, assistant superintendent, etc.
3. Supervisors or over-sisters as distinguished from head nurses or ward sisters. Importance of their teaching cannot be overestimated.
4. General duty nurses (staff or floor nurses). Select for nursing ability and for potential executive and teaching ability.
5. Sister tutor, instructor, etc. Work is largely teaching in the classroom. Status equal to that of assistants.
6. Lecturers on medical subjects, dietetics, social service, etc. Should be paid.
7. Clerical staff.
8. Provision also for library service and for health care of students.

Standards for Admission to Nursing Schools

Students must be selected for fitness for nursing.

A. Preliminary education. Committee agrees that the prospective students should be in regular attendance at a good school at the age of 17 or 18. Education should be of broad, general character with emphasis on cultural rather than on technical or professional subjects.

B. Intelligence. Intelligence tests should be used when possible.

C. Age. Minimum varies from 17 to 21. Committee recommends 20 as minimum, maximum 35.

D. Health. Secure students who are physically fit, require physical

examination once a year thereafter. Mental health of even greater importance.

E. Character and personality.

Educational Program

A. Length of nursing course. Committee agrees three years should be considered general period to be recommended.

B. Division of time. Period divided into first, second and third years, certain part of first year set apart for initiation of student. Admitted in groups and not more than two groups in one year.

C. Ratio of theory to practice in the course. Committee agrees on proportion of one hour of systematic formal instruction to ten hours of practical experience.

Standards of Teaching and Teaching Facilities

A. Teaching Facilities

1. Class and lecture rooms should be well lighted, well ventilated, quiet and comfortable, with blackboards and other standard teaching equipment.

2. The teaching of both the nursing sciences and the nursing arts require facilities for demonstration and for individual student practice and laboratory work. Without such equipment and the opportunity to make our teaching concrete and practical, it is estimated that at least a half of the value of our class or lecture work is lost. A laboratory (which means simply a work room) for the teaching of practical nursing is essential. Another laboratory should be provided for the teaching of cookery and dietetics and one for the teaching of the elementary sciences.

3. Illustrative materials in the form of charts, models, pictures, lantern slides, etc., are of great assistance in presenting a subject in a clear and interesting way and in helping students to remember. A resourceful teacher will be able to improvise and collect such materials at little expense.

B. Methods of Teaching

1. The character of the teaching should be equal to that in other professional and technical schools. It should be systematic, organized, scientific instruction, especially adapted to the needs of the nursing group, and such as to stimulate thinking and develop skill in nursing work.

2. This means that teachers should themselves be persons of good fundamental education, well informed on the subjects they attempt to teach, and, if possible, with some special training in teaching. The nurses in charge of the practical teaching in the wards and other departments of the hospital should be specifically prepared for their important teaching duties as well as those who teach in the class room.

3. The largest share of the teaching should be done by nurses, since they understand better the needs of student nurses, are more continuously in touch with them and can apply their teaching better. The sciences can be taught satisfactorily by nurses if they are specially trained for this work. Distinctly medical subjects should, however, be taught by physicians and specialists as far as possible. In clinical subjects such as medical nursing, obstetrical nursing, etc., it has

been found that better results are usually secured where a physician (or surgeon) and a nurse divide the work between them, the one discussing the diseases and their treatment and the other the practical nursing measures used in those special conditions. The physicians and nurses selected for such teaching should if possible supervise the student's practical work in the same clinical branches.

4. The lecture method has been used to excess in most nursing schools. While it has a place, class discussions, demonstrations, clinics, etc. very often bring much better results. The case study method is one of the best methods for teaching nurses to observe their patients and to apply the principles they have learned to the actual nursing care of patients. It should be introduced as soon as the students have finished their first term's work and should be developed by those in charge of the practical teaching in the wards.

Fear

EARLY in life the child must learn that there *are* certain situations which must be met with a question—that high places are dangerous, that fire burns and water drowns, that strangers are not always to be trusted. Unless we implant these rudimentary cautions, the child may not live to conquer the world. To instill caution without destroying initiative is the parent's problem. The balance of these two ingredients must be nicely adjusted in each case to the disposition and tendencies of the individual child. . . .

Fear in its extreme forms is more likely to hinder than to help in the danger situations of today; coolness and quick thinking are, as a rule, more conducive to escape.—From "Parents and the Pre-School Child," p. 204, Wm. E. Blatz. Publishers: Morrow & Co.

Proposed Rules for Class Elections

Qualifications for class officers:

1. Ability to lead.
2. Congenial personality.
3. Ability to speak in public.
4. Average grade of "C."
5. Good Health.
6. Spirit of cooperation in all school and home activities.
7. A member in good standing—dues paid.

Election shall be held the last week in January, every class having elections at the same time. Each class shall consist of the February and September Section of the same year and neither section shall have precedence over the other.

Each class shall be organized under the following officers:

1. President.
2. Vice president.
3. Secretary.
4. Treasurer.
5. Three directors.

—"Life Lines," Health Service Bellevue School of Nursing.

What Is the Technic Employed for Spinal Irrigations?

SPINAL irrigations are given now in but few hospitals, and, as far as I am able to find out, quite infrequently. This treatment is not a new one. It was used in the treatment of meningitis before the discovery of anti-meningococcus serum. It is used where the spinal fluid is so thick and purulent that it can with difficulty be drawn out through the needle. Its purpose is to wash out the canal as a preparation for the reception of serum. The measure is not often successful.

The procedure consists of making a lumbar puncture and a cistern or ventricular puncture and passing warm, sterile, saline solution into the spinal canal alternately through the upper needle and letting it flow out through the lower needle, and vice versa.

The technic involved is practically the same as that for lumbar puncture and the introduction of intraspinal serum.

MAUD C. KELLEY, R.N.

A Suggestion That Would Aid in Solving the Problem of the Private Duty Nurse

WINNIE COXE, R.N.

THE Grading Committee has spent about $35,000 in publishing the book entitled "Nurses, Patients and Pocketbooks." What has been done to assure the committee that the book is being read? Since private duty nurses are so vitally concerned, it is an absolute necessity for them, as well as others, to become acquainted with the contents and to coöperate in helping solve their own problems. They can be reached best through the alumnae associations.

The plan begins *now*. It should be launched by persons of note in the profession so as to give prestige, which is a requisite. These persons might send out notices to every alumnae association in the country that the month of November is to be set aside for "Study Week" or "Progress Week."

The president and the board of directors of each association should become acquainted with the contents of the book so that they may act as promoters of enthusiasm. The association might buy a certain number of copies of the text to be used—the number depending upon the size of the association. (After the nurses have finished with the study in the fall, it would be a most acceptable donation to the library of the school of nursing.)

The "Enthusiasm Committee" should arrange a schedule and divide the book, which contains twenty-eight chapters, or about 550 pages, into as many divisions as they think best to have classes. I would suggest two-hour periods, twice weekly, for four weeks—sixteen hours in all. These divisions might be assigned to committees consisting of three members and a chairman in each. These committees should prepare their assignments and take charge of the program at their appointed time. All should have access to the books and take active part in the class; but I suggest the committee so that the time might be more interesting, diagrams prepared and that someone might be ready with discussion.

By December 15, all classes will be over. Have each association send in an attendance report and a report of those having read the book.

It would be well for the association to offer suggestions as to how the problems might be solved.

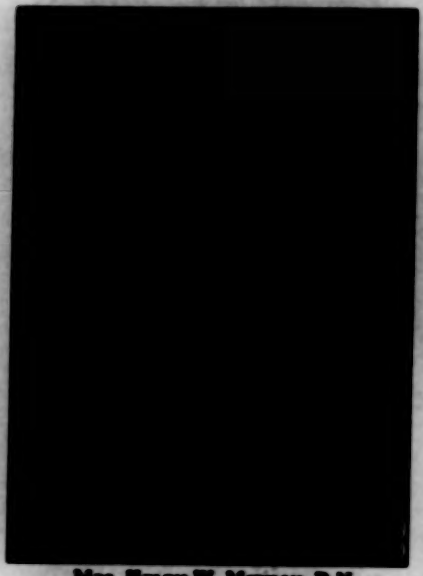
This month of study might accomplish a threefold purpose:

1. Knowledge of the problems of the nursing field would be brought home to the individuals.
2. It would stimulate growth and adjustment.
3. Aid in solving the problems which now confront us.

The next, or second part of the problem of the private duty nurse, will make it necessary for all nurses in active service to render their services, under supervision, through some organization, thus guaranteeing constant work and adequate salaries; and at the same time properly caring for the sick regardless of their financial condition. The details of this part of the plan cannot be worked out unless sufficient funds are provided. Endowments and taxation will make this possible.

Mrs. Helen W. Munson, R.N., B.S.

LATE in September, Mrs. Helen W. Munson became Assistant to the Editor of the *Journal*. She was chosen for the position because of her interest in the care of the patient and in helping nurses to nurse.



Mrs. Helen W. Munson, R.N.

This interest she has recently demonstrated by a year as general duty nurse and head nurse at the Presbyterian Hospital Unit of the Medical Center in New York City. During this time she has taught a course in Comparative Nursing Methods at Teachers College.

A native of the Middle West, Mrs. Munson had two years of Home Economics at Milwaukee Downer and three years of teaching experience before entering the Presbyterian Hospital School of Nursing, Chicago. Shortly after her graduation, she took a postgraduate course in Communicable Disease Nursing at the Durand Hospital, Chicago. She then became an assistant to Miss McMillan, the well known principal of her professional Alma Mater.

Mrs. Munson has a B.S. degree from Teachers College, where her major interests were in Administration and Supervision in Schools of Nursing.

We believe her to be admirably prepared to assist with some of the many problems confronting the profession at the present time. She is described by those with whom she has worked as "a very helpful person." Since the *Journal's* whole reason for being is that of helping nurses, it is felt that the *Journal* is very fortunate in its latest acquisition.

Independent Journalism

"TO win the confidence of the public is for a newspaper to incur an honorable obligation to its readers to be right in its decisions and predictions, in so far as human capacity can ensure infallibility. So high a standard, however, can only be aimed at, and could only be reached, through the soundest and most perfect organization. In general conduct, and in the maintenance of traditions and continuity, there is no place for arbitrary or capricious direction. Every available source of value in that national life must be drawn from impartially. Every pronouncement must be weighed as fairly and fully as that of a Court of Justice. Thus only can the reader be assured that his newspaper gives him all that a newspaper can give, and that, as it speaks, so also will a great body of contemporary thought believe."

J. J. Astor in the Spectator

Editorials

The National Association of Colored Graduate Nurses

REPRESENTATIVES of National Nursing Headquarters who were in daily attendance at the twenty-second annual convention of the National Association of Colored Graduate Nurses report that the meetings were brilliantly successful. The excellent organization and execution of the program were due in large measure to the leadership of Carrie M. Bullock, the very able president, and to the splendid planning of Marion J. Pettiford. Each session was a potent reminder of the important social forces represented by the two hundred delegates. The convention will go down in history as that at which Adah B. Thoms presented her interesting "Path Finders," the first published history of colored graduate nurses, a book which is destined to find a place in all nursing school libraries and which sets a lofty goal for the race.

It was no surprise to find that the interests represented and the problems discussed parallel those of other professional nursing groups. There is, for example, the problem of distribution. The Grading Committee has again and again stressed the faultiness of distribution of nurses, the tendency to congregate in certain cities, leaving other areas un-nursed. Negro nurses face this problem in an acute form. Opportunities for securing education and training are to be found more abundantly in the North than in the South, but the majority of those who need their patient, sympathetic, understanding guidance on the road to health through nursing care are in the South. It is a problem pressing on the deepest sympathies of such women as Petra Pinn, an ex-president of the Association, who, according to the history, "has chosen as her life work to serve in small Southern communities."

Another parallel is found in the need for postgraduate work. In a study of postgraduate courses made by the *Journal* and published in June, it was found that a number of hospitals offer postgraduate opportunity to negro nurses. University courses are likewise available.

A third parallel is found in the make-up of the groups. There are always the few who lead and the many who follow. The responsibility for leadership in nursing today is a heavy one. Nursing, quite apart from racial or geographic considerations, is going through the deep waters of self-analysis and of reorganization. It is a time for concentration on fundamentals. These are the qualifications and the preparation of those who aspire to be, in a true sense, professional nurses. The road just ahead is a steep one and "new professional heights cannot be scaled without knowledge," but colored nurses will not falter, and they will win their way to a higher level of service and so to more generally recognized status as nurses and as citizens.

Student Allowances

TWO newspaper clippings focus attention on a problem which must be faced. One announces that

"Blank School of Nursing" is "now accepting applicants for next semester." It adds the date and "for further information address Superintendent of Nurses."

The second clipping reads: "Opportunity to learn nursing. Salary from start; accredited school; full maintenance; uniforms supplied; students enrolling September first." It concludes by giving the name of a hospital.

The first advertisement is dignified and professional in tone, even though it gives no indication of the school's educational facilities. The second is a flagrant example, not only of unprofessional advertising, but of wholly unsound thinking on the subject of a *school* of nursing. Any institution which is thinking in terms of *salary*, and which offers salary as lure for student nurses, is thinking of getting its work done. It is not thinking in terms of educating young women to practice nursing, even though it may call itself a school.

True it is that student nurses are an "administrative asset" to hospitals, but any institution which calls itself a school has but one function. That function is to teach. Students do not receive salaries for being students; if salaries are paid, it is because the institution is paying workers for service whether it does it under the guise of education or not.

The payment of "salaries" and, indeed, even of modest allowances to student nurses needs some clear thinking. Ostensibly, allowances are paid to enable young women, otherwise financially unable to do so, to secure an education in nursing. The fact that some of the schools which long ago abandoned this system but give superior preparation for the practice of nursing always have long waiting lists of desirable applicants, discounts that argument. These schools usually have loan funds for the benefit of needy students, as also do those which have adopted the sound academic principle of requiring tuition fees.

At the present time, many hospitals are concerned over the rising costs of nursing education. Say they, "We could save thousands of dollars each year if we abandoned the practice of giving allowances." So they could, but—could they do it justly? Are the hospitals which make this statement giving their students a preparation for the practice of nursing comparable in value to the amount of service rendered the hospital? It is a searching question. It can be answered only by careful studies of the cost of nursing education and the cost of nursing service.

It is no new question. Miss Goldmark discussed it in the so-called Rockefeller Report of 1923. She said, in part:

> In general the hospital's point of departure must be the cost which *would be* entailed for the nursing service without a school of nursing to draw upon. It has been proposed that student nurses, instead of being maintained by the hospital in return for their services, should pay for their board and lodging during training and themselves be paid for services in excess of those which are strictly educational.

Today the economic difficulties of hospitals and the ever increasing demands upon nurses, necessitating broader and deeper preparation, make this an extremely live question. This was brought out by the discussions at Montreal which we published in last month's *Journal*. One by one the hospitals and schools are facing the issue and are making studies of their own situations. Already it is clear that allowances can justly be omitted if the teaching is of a high order. Under such conditions desirable students will apply for training.

Probably the time is at hand when student nurses will pay for their tuition and, in turn, be paid for service rendered the hospital when employed in non-educational duties, controversial though that point may be.

We need not wait, however, for studies of any sort before condemning the use of the word "salary" in connection with student nurses; salary and student are irreconcilable terms.

Medical Education

DR. N. P. COLWELL, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, reminds us that Colonel Ayres' reference to medical education, on page 928 of the August *Journal*, gives an erroneous impression, since it omits any mention of the fact that the medical profession, through the American Medical Association, was at work "putting its house in order" before the Carnegie Foundation gave the powerful assistance which culminated in the Flexner Report. In order that we may give the facts as recorded by the American Medical Association, we quote on page 1208 from an editorial in the *Journal of the American Medical Association* of August 17, a number devoted to medical education. The discussion is timely and stimulating. Just as the medical profession is able to report the sincere coöperation from the deans of all the better medical schools, so can nursing report the whole-hearted coöperation of all the better schools of nursing in the present effort to put the house of nursing in order. One of the most striking features in the reform of medical schools was the pooling of resources. For example, in one city the two schools were combined and put under the aegis of the local university, with such spirit that one of the great foundations gave very substantial assistance.

"Heaven helps those who help themselves" is a time-worn adage. It seems to have applied most generously to the reform of medical education, as many of the schools have been the recipients of substantial gifts and endowments. Nurses know that reforms in nursing must come from within the profession; financial and intellectual aid may come from without, but the desire for improvement, the desire to initiate reforms must come from within. They know, too, that "when the desire cometh, it is a Tree of Life."

"BUT in the enormous development of material interests there is danger lest we miss altogether the secret of a nation's life, the true test of which is to be found in its intellectual and moral standards. There is no more potent antidote to the corroding influence of mammon than the presence in a community of a body of men devoted to science, . . . We forget that the measure of the value of a nation to the world is neither the bushel nor the barrel, but mind; . . . The kindly fruits of the earth are easily grown, the finer fruits of the mind are of slower development and require prolonged culture."—Sir William Osler, in "Aequanimitas."

Our Contributors

Nurses all over the world will welcome the article and the book from which the material for "Maternity Nursing in Home and Hospital" was taken because they have already profited by the author's teaching at the Maternity Center, New York City. Miss Zabriskie is Assistant Director.

M. Cordelia Cowan, R.N., B.S., is Educational Director at the Women's Hospital, New York City, which gives postgraduate courses in nursing.

Sister Magdalene, R.N., Ph.B., is the very progressive Superintendent of St. John's Hospital School of Nursing, Springfield, Illinois.

Caroline T. Snyder and Mrs. Martha A. Brown Teter, R.N., are respectively Superintendent and Supervisor of Nurses at Trinity Hospital, Little Rock, Arkansas. Mrs. Teter is a graduate of St. Mary's, Rochester, Minnesota.

Robert A. Kilduffe, A.M., M.D., is Director of Laboratories at the Atlantic City Hospital, Atlantic City, New Jersey.

J. J. O'Hearn, B.S., M.D., has just completed his internship at Cook County Hospital, Chicago, and Minnie Strube, R.N., is supervisor of the postoperative recovery ward in the same institution. She is a graduate of the Illinois Training School for Nurses.

James I. Coddington is Secretary of the Harmon Association for the Advancement of Nursing which is concerned with aiding nurses to provide for annuities.

Miss Noyes, who has long been Chairman of the American Nurses' Advisory Committee of the Florence Nightingale School at Bordeaux, has reason to rejoice over the magnificent response to the Committee's appeal for funds to complete the school.

"An Endowed Bed" came to us from Beatrice M. Clutch, R.N., Instructor at Blessing Hospital, Quincy, Illinois, while she was taking a postgraduate course at Peabody College, Nashville, Tennessee.

May Agnes Burgess, Ph.D., in "Talk Your Speech" reveals the secret of her own successful delivery.

Ann Doyle, R.N., B.S., collaborated with Clara Vervielle, R.N., B.S., in preparing the article on the work of Lutheran Deaconesses, as Miss Vervielle, who is the daughter of a Lutheran clergyman, had collected some valuable data for a course in History of Nursing at Teachers College.

Vera L. Schell, R.N., is a graduate of the Jefferson Medical College Hospital Training School for Nurses, Philadelphia. She has held various positions and has also done private duty and industrial nursing. Her paper is based on her experience as instrument nurse and assistant in the Chevalier Jackson Bronchoscopic Clinics in Jefferson, Graduate and University Hospitals.

Ella M. Bothell, R.N., is a graduate of what is now known as the Evangelical Deaconess Hospital, Freeport, Illinois. She has had a varied professional experience which includes private duty, Army and Veterans' Bureau Service.

Winnie Cano is a postgraduate student at the Illinois Training School for Nurses, Chicago.

Margery Trotter, R.N., is a head nurse in the Pediatrics Department at Bellevue Hospital, New York City. Maud C. Kelley, R.N., B.S., is the well known supervisor of the same department. Katherine J. Densford, R.N., is Assistant to the Dean of the Illinois Training School for Nurses, Chicago.

Out of the Mail Box

I ENJOY reading the *Journal* immensely; even my aged mother reads it often. As I have been off duty since the fall of 1934, I have been able to read the *Journal* every month, with few exceptions, but only through the courtesy of my friends who sent it to me and also made me a present of it last Christmas.

Missouri. K. K.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

Pre-Service Training for Head Nurses[1]

MARGERY TREIBER, R.N.

WE had in our Pediatric Department, this last year, five students who were taking the head-nurse course. Because of our participation in the program, I have been asked to describe the pre-service course.

In order to make perfectly clear just what is meant by the terms *head nurse*, *supervisor*, *in-service* and *pre-service* training, let us distinguish between them. "A head nurse is a graduate nurse who is in charge of a ward or of a similar unit." By pre-service is meant the training given in preparation for a position before the individual is actually employed on salary. The service includes practice in the duties of a head nurse only so far as it is a definite part of the course. Pre-service differs from in-service in the fact that the preparation precedes the actual service, whereas in-service preparation may be conducted while the nurse is employed as a head nurse in an institution. Classes given especially for the head-nurse group by physicians or by supervisors of departments while the head nurses are on the job are examples of in-service training.

Why do head nurses require pre-service training? In the past most head-nurse training has been acquired through experience on the job. Provided the nurse has good ability, this method produces some excellent head nurses. It takes a long time, and there is always the chance that she may fail to learn what a good standard of head-nurse work includes.

The exhibits here at the convention emphasize the fact that all nursing is more complex than it was fifty years ago and, therefore, if it is to be done adequately, it requires a wider knowledge and a higher degree of technical skill. Scientific advancement has revolutionized medical practice and all the work done in a hospital. In application of these principles to the actual care of the patient, such great responsibilities have been delegated to the head nurse that it would seem to indicate that she needs preparation to assume them all efficiently.

The head nurse is one of the most important persons in the hospital. She is responsible to the patient for his care. It is the head nurse who is finally responsible for seeing that the patient gets the good from the vast machinery of modern hospital service. She is responsible to the hospital for seeing that its resources placed at her disposal are used in the most effective way for the good of the patients in her ward. She is responsible to the doctor who must be able to depend upon her coöperation at all times and upon her skill and wise judgment in the many crises which occur during his absence.

[1] Read at the 29th annual meeting, National League of Nursing Education, Atlantic City, N. J., June, 1929.

The head nurse is a hostess of her ward. To the patients and visitors of her ward she represents the service and spirit of the hospital, and to this extent she interprets the hospital to the community. Upon her sympathetic and intelligent exercise of this function the reputation of the hospital is largely built.

The head nurse is, or ought to be, a teacher. Instructions as to the method of preparing a formula, which the head nurse gives to the mother who is taking her baby home from the hospital, is only one example of the kind of teaching which the public has a right to expect of her. It is, however, the student nurse who falls most constantly and directly under the influence of head-nurse teaching. What this influence upon the student is to be, depends upon the natural ability of the head nurse, the time she has to give, and upon her preparation for this responsibility. The young graduate assuming head-nurse responsibilities without specific preparation naturally follows the example set for her by the head nurses of her student days. The effect upon our future head nurses of working under good head nurses is so great that it cannot be measured.

The place of the head nurse is a key position in regard to the development of future executives of all grades. Most of our executives and many of our teachers have been head nurses first. It seems logical to believe, therefore, that training of head nurses is basic and will work toward the elevation of general nursing standards. When so much depends upon the preparation of the head nurse, it would seem very important that her training be of the right kind and not left to chance.

In an attempt to meet the need for trained head nurses, a coöperative course for head nurses was planned last year by a joint committee consisting of superintendents of several nursing schools and of the staff of the Nursing Education Department of Teachers College at Columbia University. It was clear that head nurses cannot be adequately trained by sending them to college only. The course, therefore, consisted in a program of correlated theory and practice, the former being given at Teachers College and the latter in hospital wards under the joint supervision of a member of the college staff and the supervisor of the department in the hospital in which the student was having her practice. Six hospitals entered into this program: Bloomingdale, Bellevue, Englewood, N. J., Presbyterian, Willard Parker and the Woman's Hospital. This meant that in nearly every case the applicant was able to choose two services for her practical experience.

The college subjects consisted of Educational Psychology, Hospital Economics, Comparative Methods of Practical Nursing, Mental Hygiene and Public Health. This meant eight hours of class, weekly, with about twelve additional hours for study. The field work consisted of twenty-eight to thirty-six hours of practical work per week. The three main phases were as follows: First, that related to nursing technic; second, that concerned with increasing knowledge of the subject matter of the specialty; and third, that pertaining to housekeeping. It was expected that the student make a definite contribution to the ward in the form of improved nursing care, more efficient housekeeping and better ward teaching. At the end of the term, the student was given a series of tests to determine her proficiency in each of these three phases of her practical work.

The program of work for the second term extended that of the first. Here again the student had to acquaint herself with the routines of the new service, to broaden her knowledge of the subject matter of the specialty, and to indicate to the head nurse her ability to take expert care of all types of patients in the new service. The student gained experience in conduct of nursing clinics, in development of experience, efficiency and self-rating systems, and in the various types of ward teaching.

Experience which the Committee has gained during the past year seems to indicate at least three very essential requirements for successful training of head nurses: First, promising young women as applicants; second, a good field; third, coöperative personnel in the hospitals.

The course is planned especially for the inexperienced graduate, and it appears unwise to include, with these students, people of considerable experience, unless the program is adaptable enough to provide what they have not had. On the other hand, the strain of adapting to a new and strange hospital environment was apparent to those who came in daily contact with these young women. Good physical condition is necessary and a vacation before beginning the course is desirable. Some provision should be made whereby the hours of ward duty might be shortened during the first weeks when the student is concentrating her efforts upon principles and upon the subject matter of the specialty. This adaptation would not only be advisable from a health standpoint, but it would also contribute to effective performance of the increased teaching function in the second term.

It was found that there are certain definite qualifications which a hospital should possess in order to provide the most valuable experience for field students. For example, the hospital should be near enough to minimize the cost of travelling as well as to save the student's time and energy. The opportunity to make good use of the college library is dependent upon this factor. The nursing education staff of the hospital should have accepted the plan and be in hearty sympathy with it. They should have sufficient faith in the undertaking to be willing to allow the student to experiment a little and to delegate some responsibilities to her. Nurses whose student experience was gained in a small hospital might profit by experience in a larger institution. The graduate of a large school might receive benefit from work in a smaller hospital. The size of the hospital selected is of less importance than the activity of the service chosen, that is, there should be sixteen to twenty admissions, per bed, per year. This is necessary to ensure opportunity for the student's review and for increasing her knowledge of the specialty. It appears desirable that the student should not be assigned to the hospital from which she graduated. The new situation is challenging. Practices which the young graduate would take for granted in her own hospital arouse her interest and stimulate questioning and open-mindedness which are wholesome antidotes for narrowness and provincialism. Because of the intensity and variety of these new impressions, the sum total of learning is likely to be greater in a new field.

Another method of enriching the experience is to offer two services per year, preferably in related subjects, such as pediatrics and communicable disease, or obstetrics and gynecology. The service should be sufficiently large to permit one or two changes of

wards during the term. Such changes should be made, if necessary, to secure variety of experience or to promote harmony if personality conflicts occur.

Wards to which students are assigned should be adequately staffed. It must be possible for good care to be given if the student is to improve her own nursing. Her conception of head-nurse responsibilities should not be formed by the one-sided picture presented by the ward in which "mass production" is the chief aim of nursing. The ward should contain a sufficient number of student nurses to give the field-student experience in working with them.

Careful study of ward personnel is advisable before definite assignment to a ward is made. A head nurse who is eager to conduct all her own teaching, one who expects mature judgment and experience and is, therefore, unduly critical, or the head nurse who is frankly indifferent, can mean failure for the student assigned to her unit. On the other hand, an appreciation of the contribution which the student can make will help the head nurse to welcome her presence. Knowing that such a contribution is expected encourages the student and stimulates her best efforts. The supervisor can do much to prepare the way for mutually friendly relations by a conference with the staff nurses before the arrival of the field students. In this conference the purpose and plan of the course might be explained and the advantages to the department and its responsibilities discussed.

Pre-service, head-nurse training is a new venture in nursing education. The group responsible for it commenced it entirely from an experimental point of view and in the light of this experience, the plan for next year has been considerably changed. It is recognised that the plan followed is only one of many ways in which courses can be developed in other parts of the country.

It has been suggested that any group of hospitals having access to a college or university could offer a pre-service, head-nurse course. A centralised school of nursing might secure an expert person who, with the assistance of the participating schools, could arrange for desired college courses, assign students for their practical experience and teach the principles of ward management. On the other hand, one school might give some type of pre-service training, provided a suitable college or university is available for giving part of the instruction. In this instance, the director of the course should have had a rich and varied experience in order to bring to her group the best practices of many different schools of nursing.

After this year of immediate contact with the students assigned to our Pediatric Department, our personal reaction to the course is one of pleasure in the stimulation which contact with these young women gave to us and to our head nurses. We believe that the experience has been mutually helpful. The faith of the hospitals in the success of the course has been shown by their desire to secure these students as head nurses and to continue the field work in their own schools next year.

Field Course for Student Supervisors[1]

MAUD C. KELLEY, R.N.

I DO NOT remember when I first heard of the plan for field work in supervision, nor who first told me about it, but I remember that I felt sure that it was work for which our pediatric department at Bellevue could furnish a good field. We have so many active wards that those who wish to become pediatric supervisors could find good clinical material to round out their knowledge in this respect. This would also furnish excellent material for teaching the bedside nursing peculiar to all the principal children's diseases. While I felt that what we had to offer was exceptional, I was just as sure that such students would be of great benefit to us. They have been of much greater help than even I anticipated, and we are very anxious to do our part to develop the course so that it may be of the greatest possible value to the student supervisor.

As it is a new venture, it must be expected that its value will increase gradually through a series of developments and adjustments. Members of the college staff; supervisors and head nurses of the department; and field students in head nursing and supervision, will all need to work together, each contributing as many helpful suggestions as she can, in order to round out the course so that it may reach a high standard. My contact with the work has been limited to the Pediatric Department at Bellevue, and I am confining my report to the department with which I am familiar. There seem to be three important phases to describe: the prerequisites of students in supervision, the prerequisites of a field for training students in supervision, and a description of the course as given.

Prerequisites of Students

BEFORE the students come to us, they have completed a year's successful experience as head nurses, and have finished a year's preparation at Teachers College. This preparation consists of a basic course in: nursing supervision, curriculum-making, teaching in nursing schools, teaching of principles of nursing practice, history of nursing, elements of public health, mental hygiene, hospital economics and an introduction to sociology.

With this foundation, their field experience is really laboratory work in which they try out the methods taught and the various experiments suggested by the interaction of their own experience as head nurses, their year's study at college, and the hospital situation which forms their field. It furnishes an opportunity to test their own ability to materialise a plan and to carry it through, as well as to test their personal adjustments with people.

The field course in supervision was begun two years before that in head nursing. The supervisory course brought out the need for the course for head nurses. The student supervisors always expressed regret that, as head nurses, they had failed to see at all so many of the opportunities which they had had for good management and good teaching when they were in charge of wards. Thus they not only deprived the students of much possible

[1] Read at the 39th annual meeting, National League of Nursing Education, Atlantic City, N. J., June, 1929.

teaching, but themselves of the benefit derived from teaching experience and the pleasure attendant on efficient ward management. From this it would seem that the student supervisor would be fortunate if she could take the head nurse's course before she had her year's experience as a charge nurse. Of course, few can afford to take both, but the supervisory course often includes work which would be unnecessary had her year's head-nurse experience been more profitable. The time spent in filling in deficiencies in such experience might profitably be spent on more strictly *supervisory* training.

This applies particularly to the student supervisor who is not thoroughly familiar with the field in which she wishes to supervise. For the supervisor, as we understand the term today, is a teacher, and teaching makes desirable as expert a knowledge of the subject matter as possible. This means knowledge of all the principal children's diseases as to cause, symptoms, nursing care, prevention, public health aspects, etc. Her knowledge needs to be much broader than that of the student who has just completed her hospital course. (Besides this, the supervisor's direction of her department includes the housekeeping, management of wards, teaching of students, and staff education.)

Field Requirements

IN order that the student may have adequate opportunity for practice and experiment in all phases of the work, the field must meet certain requirements. The most important requirements for the field are:

a. The service must be active.
b. There must be a good variety of cases.
c. The field must be large enough.
d. There must be a definite piece of work to be done in developing the head nurses, increasing the ward teaching, and improving the program already going on.
e. The field should afford the student supervisor an opportunity to test:
   1. Her initiative.
   2. Her ability to adapt herself to a situation and at the same time make it better. (The situation should be sufficiently complex to need analysis and planning.)
   3. The field should give her an opportunity to put her plan into operation and test the results.
   4. It should give her an opportunity to observe the supervision of others, such supervision to include as wide a variety of types as possible so that she may be able, through comparisons, to determine the points of strength and weakness in each and discuss with her field supervisors their applicability to *her* situation.
f. The field must have an adequate personnel. This would include:
   student nurses.
   postgraduate nurses.
   general duty nurses.

   The most important factor is that the staff of the department be willing to delegate *some* responsibility to the student and allow her to use her own initiative and to experiment.

   A field with an unchangeable program, organized very definitely, is primarily good for observation purposes rather than for the regular field work of the student herself.
g. It is a great asset to the student when a staff educational program is in progress, in which she is included.

Description of Courses

WHEN the student supervisors came to Bellevue, a general plan was worked out by the field supervisor from the college with the concurrence of the regular staff of the department. The greater part of the first two weeks consisted of observation.

1. The student's first day was planned so as to give her an idea of the history of the hospital, the number and position of the various departments, and the organization of the nursing staff.

2. Next the students were sent to

the first department in which they were to work. That the student might obtain a richer experience, the time, with two exceptions, was divided between two services. This gave a better opportunity to observe the varied methods of supervision.

3. The first days in the actual work were spent with the nurse in charge of the building and the nurse in charge of the housekeeping. This experience gave her an opportunity to observe the organization of the building as a whole—the number of wards, various ward routines—as linen exchange, serving of diets, etc.

4. The next few days she spent with the nurse in charge of the department, who tried to give the student supervisor a general idea of the geography of the department, the various systems which we have developed, with the intent of giving our students careful personal supervision, teaching, and help, as needed. This included the ward routines as posted, procedure books, treatment books, the library content and system of checking up on distribution of books, general plans for ward and classroom teaching, general plans of office administration and method of rotating the students through the service. The case studies and nursing-care books were explained. The student attended the clinics, demonstrations, doctors' lectures and nursing classes. This superficial acquaintance with the work as a whole enabled her to place her contribution in its relation to the entire service and enabled her to utilize all the facilities available.

5. With this foundation laid, she gradually assumed a position of responsibility, studying little by little the details of teaching and administration with the purpose always in mind of devising better ways of meeting the difficulties peculiar to her field and contributing finally a well-thought-out plan which, after conference with her field supervisor and the nurse in charge of the department, she might try out, changing it and adapting it during the remainder of her time on the service, as her experience indicated.

With this knowledge of the general situation, she is given one or two wards for her special field and an opportunity to study this field intensively, becoming thoroughly familiar with the clinical material on these wards, their routines, and the personality of the medical staff and the nursing staff. Conferences are held with the field supervisor in which the situation, as revealed, is discussed.

As a part of her work, she discusses with head nurses the assignment of patients to students, helps students with case studies and nursing-care books, suggests appropriate library references, good cases to study, etc. She corrects and grades the work of students, both written and practical. Emphasis is laid on the essentially experimental aspect of the work and the importance of ever trying to work out more satisfactory solutions and of encouraging the student to have the same attitude. Her supervision of her own special wards includes also individual conferences with her head nurses for the purpose of helping them to become more efficient in their field and for the purpose of securing their coöperation in working out better methods of conducting morning circle, giving ward demonstrations and bedside clinics and correlating classroom and ward teaching.

During this time she continues to attend classes, etc., gradually assuming responsibility for giving demonstrations, assisting at clinics, proctoring doctors' lectures, and occasionally giving the nursing class

following them. After attending such a lecture, she works out with the other supervisors, appropriate methods of drill, short-type examination questions, etc., to clinch the material taught by the doctor and to supplement it with appropriate nursing care.

At the same time she takes part in the supervision of the whole service by making rounds at intervals on *all* the wards and by occasionally making census rounds in the evening, reporting to the night supervisor of the department and sometimes receiving her report in the morning.

Short conferences of the supervisors of the department were held daily and longer conferences weekly. In the weekly conferences the class and ward work of the student nurses was discussed and average grades determined. There was also discussion of class and ward problems.

Weekly joint conferences of head nurses and supervisors of the department were held. These the student supervisor attended and contributed to the discussion and suggestions. As a definite part of their work the student supervisors were asked to make suitable plans for such conferences, introducing points which their experience suggested would be helpful.

As a final means of obtaining a grasp of the department as a whole and all the work which it carries, the student supervisor spends a few days in the office. Here she goes over the daily time schedules of the head nurses, seeing that the wards are properly staffed when the head nurse has her afternoon, during the hours when work is heaviest, etc. When she finds schedules not well balanced, she makes suggestions to the head nurse for revision. She makes out weekly programs of class and office work, assists in the care of the library. She gains familiarity with the routine of the office secretary and prepares digests of lectures, makes out tests, etc., for her to multigraph. She learns the system of rotation more thoroughly and, with her knowledge of the student and graduate personnel, makes out the weekly changes of nurses from day duty to night duty and from one ward to another. This necessitates a knowledge of the personality of each of the fifty to seventy students and of the stage of their pediatric experience. She must provide for the needs of the milk laboratory and of the eleven wards to which they are to be distributed. It means going over the record cards of the students to check up on deficiencies in their work and conferring with them regarding such deficiencies.

To Summarize

THE aim of the training from the field standpoint is to place the student supervisor in a position where she will understand all the workings of the department. It attempts to give her the experience which will help her to organize and carry forward a good program of hospital management, housekeeping and teaching. This teaching includes the instruction of students, head nurses and supervisors through personal interviews, group conferences, lectures, classes and clinics.

Staff Education[1]

In-Service

KATHARINE J. DENSFORD, R.N.

THE aim of the present paper is to present the program of "In-Service" Staff Education as carried out during recent years in the Illinois Training School for Nurses under the direction of Laura R. Logan, Dean of the School. In doing this it aims also to indicate certain types of staff education which would seem to be desirable in schools of nursing at the present time. Our thought deals with the education of nurses on duty, or so-called staff education. For our present purpose we may accept Miss Marvin's definition of staff education as being "a tentative program for developing workers on the job in which they are engaged as full-time workers."

We do not assume that this program has within it all that is new. For many years—as a matter of fact since nursing schools began—there has been staff education, perhaps under a different name or no name at all, but wherever there were earnest women responsible for the care of sick people and for the preparation of the students, there, in frequent instances, could we have found some form of staff education. Many of the older members of our profession will recall very worth-while plans which were carried out in their own schools or which they themselves initiated. It is also true that in many parts of the country today many good programs of staff education are being promulgated quietly and unostentatiously, about which we know nothing because circumstances have not been such as to bring them to public notice.

The program at the Illinois Training School for Nurses has been made to include all members of the staff—faculty, supervisors, head nurses, general duty nurses, and attendants, taking in, in fact, a program for everyone. This has varied at different times and for different groups though a major portion has been carried out consistently from year to year.

There are, in the main, two types of staff education. They are, first, that which improves the technical skill and ability of the workers, and second, that which enriches their general background and understanding.

Of the first, or technical type, perhaps the most effective form of staff education is the informal sort—the kind of education which the worker assimilates in the actual performance of her duties from her daily contact with patients, doctors, nurses, and others. In a large county hospital for acute disease (3,300 beds) which is used as a teaching laboratory for student nurses, graduate nurses, medical students, interns, and practicing physicians, the amount of practical knowledge and skill acquired from observation and daily experience is exceedingly great. Particularly is this true of the general-duty nurse, who is constantly having the advantage of working in units in which definite teaching programs are being given to other groups than those employed as full-time workers. The worker in such units cannot help learn if she be even half alert. Nor does this apply only to the general-duty

[1] Read at the 39th annual meeting, National League of Nursing Education, Atlantic City, N. J., June, 1929.

nurse—it applies to every one of us. We learn constantly on duty in the performance of our regular day's work. It is of course necessary, if we expect this informal type of education to be of great value, that we assure a proper laboratory in which the worker shall perform her duties. We learn by doing, but we may learn poor as well as good methods; so that those of us responsible for schools of nursing should see that the daily performance of duties is well done if we are to expect good results from such informal education. Personally, I cannot stress this phase of our staff program too much, for I feel that the best education we can offer those in our employ is to see that the nursing in the different departments is well done. Not until we have proper care, properly given, in our hospital units can we expect our staff education program to attain maximum, or even moderate, efficiency.

Another way in which nursing service can be improved is through the routine reports, particularly those given at morning assembly. No better opportunity exists in any hospital for instruction and correlation of theory and practice than is found in well conducted morning and evening assemblies. Here it is that clear, accurate reports of observation and care of patients are, or should be, given; and here, if anywhere, is an unsurpassed opportunity in the daily routine of actual care to stress for an entire group the proper care of each patient with each type of disease. If these reports could be prolonged even a few minutes, I believe they could be made of much more value from the point of view of teaching. We are so prone to think of such reports as of a routine nature and of little value, and so they may easily be without careful handling, whereas in reality they can and should be made of infinite worth. An assembly carefully planned and carefully conducted, with group participation, can be productive of a very much improved nursing service. Several supervisors and head nurses have developed such assemblies, making rich the educational gains to the workers in their individual units. They have stressed not only the unusual and interesting case; the unusual and interesting and new treatment; the care of particular types of patients; the good and unusual case studies of students and graduates; but also they have stressed equally the typical and less striking case; the typical and less striking or old forms of treatment; the routine care of the average patient; and sometimes, the less perfect case study. This emphasis on the usual as distinguished from the exceptional, should be productive of much good to thousands of patients, the majority of whom are ordinary cases.

In addition to the material presented from the hospital it is customary with some supervisors and head nurses to have local, state, and national meetings reported to the entire ward group by the nurses of their divisions who have been privileged to attend such meetings. For example, several nurses attending the Mid-West Division of the American Nurses' Association reported the outstanding programs of this meeting at morning assemblies.

Then there is the more definite assignment of case studies to the graduate personnel—the study of individual patients with such diseases as pneumonia and typhoid. An effort has been made within the past year to have each of our 200 general-duty, graduate nurses make one or more such studies. Not all have done this, but those who have, have been benefited.

An even more interesting procedure has been tried out in several departments, that of having the entire group of the particular department meet together for discussion and study of particular diseases or treatments. This is being done rather generally and informally at the present time, though we have had very definite programs for the departmental conferences, a copy of one of which is appended to this paper. These were perhaps as helpful as any conferences we have had, as definite departments were responsible for making out the programs and for posting the programs and bibliography several days in advance, so that when the conference was held, those attending were ready for appreciation and discussion, not only on the basis of their experience, but also on the basis of recent and up-to-date reading on the subject.

In this discussion of staff education would come also the meetings and conferences of the different nursing-school groups—executive, faculty, supervisor, head-nurse, and general-duty nurse. While the purpose of these meetings is mainly otherwise than educational, being, in fact, chiefly administrative and executive, there is also a very large element of education in them, depending upon the ability and qualities of those responsible for the conduct of the meetings. Though it is difficult to evaluate, in terms of education, meetings and conferences held primarily to get a certain work accomplished, rather than a certain educational program effected, that value exists in such meetings is evidenced by the interest and understanding which have evolved from them.

In this connection it is well to mention, in so far as the faculty is concerned, the building up of the present curriculum and the publication of our catalogue and bulletins. Attempted for the purpose of getting certain tasks done, they yet afford unlimited opportunity to each faculty member to assist in arranging these publications. No one member was responsible. Effort was made to see that each person had as much experience in her preparation, and learned as much from the performance as possible. All of this required time—much time—but it was time well spent. Perhaps one result of such work has been to make most members of the faculty see the school in terms of the whole rather than in terms of their own particular department.

A more definite and formal type of staff education for general-duty nurses has been tried—that of having one of the faculty responsible for meeting all new graduate nurses and spending the first two days in teaching them our methods of procedure in the fundamental care of patients. Such a plan necessitated grouping new employees as to entrance dates. This was not always feasible either from the point of view of the hospital, which may need one nurse one day and no more for several, or from the point of view of the nurse who may not feel, financially, that she can wait until the next group of graduates enters. So that while this method has been helpful in many ways—particularly that of making the new graduate feel more at home in her new position—we have found it more practicable to have the department, to which the graduate is going, responsible for giving her this teaching within the department.

Another bit of teaching for general-duty nurses was done some time ago when regular classes and demonstrations were given to these nurses by the instructor in introductory nursing. The purpose was, of course, to familiarize all graduates, representing many

different states and at one time, indeed, seventeen different countries, with the methods used in the school and to bring them new and changed means of care.

All departments have been recently revising nursing procedures. This work is in the hands of a committee but department heads and assistants as well as many general duty nurses in the departments have been helping in the process. While printed procedures make for more definite and accurate work, it is well to guard against rigidity. Procedures to be of most value should be plastic.

Then there is the rotation of the general-duty nurse in the various services. While it is true that in a teaching hospital students must be given priority in assignment, it is also true that graduate nurses do move from ward to ward and from assignment to assignment in the same ward. Functional assignments are made to the graduate, such as senior duty, or acting as assistant to the head nurse. Or she may be given a case assignment, as for example certain patients with pneumonia or typhoid. I believe we should do much more in the matter of rotating graduates and teaching them on each service and assignment. This is relatively easy in a hospital with an entire graduate staff, but perhaps more can be done than at present in the hospitals with schools of nursing. Those nurses desiring to remain on one service may be permitted to do so.

There are also the ward demonstrations which are being given constantly. New methods of medical and nursing care are observed and carried out. For example, a new method of transfusion was carried out in our post-operative ward. The doctor on the service demonstrated the procedure with the assistance of certain nurses to the entire staff on that service.

The departmental conferences for supervisors and head nurses have also been helpful. These are held in some departments monthly and have for discussion, among other things, such subjects as the sterilization of glucose and methods of applying hot dressings, for the surgical group; proper care of the cardiac, for the medical group. In other departments the conferences are held weekly. In one department the grading of the student's nursing practice is done by the entire group of head nurses at these conferences with the assistant dean in that department presiding.

Many supervisors and head nurses have also taken advantage, during this past year, of certain field trips which were planned for them in the city and neighboring communities.

It goes without saying that an effort is being made to stimulate all staff members to more regular use of the nursing journals. Articles are frequently referred to on the wards, and nurses are encouraged to bring items of interest in nursing care of patients to the division groups.

In one department in which the carrying out of certain nursing treatments requires a highly specialized type of knowledge not usually included in a general nursing curriculum, lectures have been given on the theory and proper administration of such treatments, with demonstrations by the supervisor specially trained for this work, and return demonstrations by the members of the head-nurse staff. This enables the head nurses to direct the work of the student nurses in giving these same treatments much more intelligently and with much greater confidence.

For head nurses, the most definite program has been the class in Ward Administration, open to head nurses and general-duty nurses who may wish

to prepare for the position ahead. Many supervisors have also attended these classes, which have been repeated three times during the year and which constitute a minor credit. In connection with this course has come much that has been helpful—not only better administration, but better methods and attitudes of approach. Especially may be mentioned the spirit of research—the spirit of scientific approach to the problem of nursing care, evidenced in several ways, two of which are an attempt to find what adequate nursing care is for certain types of patients, and to work out the time studies, which indicate the actual length of time it takes at different hours of the day to give such care to the different types of patients. Some of these studies have appeared in the *American Journal of Nursing*.

Not all departments have arranged definite teaching programs for the attendant group, but in one department a definite course of talks and demonstrations—sixteen in all—are given to all attendants in the department. These talks and demonstrations stress the duties of this group, and the group is expected to demonstrate back all procedures taught it. Another department has ward conferences for its attendants which, while less formal in plan, aim to stress the same things—the duties of this group in giving good bedside nursing care. Much individual attention and teaching are also given in all departments to this group, particularly to the new members.

An arrangement familiar in university circles is that making possible exchange professors or instructors. When we consider the many outstanding women in the nursing profession today and the work they are doing, I always covet for more than the limited few working with these leaders, the opportunity to have that same contact. Would it not be possible to arrange a system by which (in the better schools at least) there might be an occasional exchange of an assistant, instructor, supervisor, or head nurse? Certainly such a plan would bring untold advantage to the individual, and I believe most schools could make such an arrangement, at least for a limited and select few of their staff, in the long run benefiting notably the nurses, the schools, and the profession.

A further and last plan for staff education of this type—at least for certain members of our staff—should, I believe, be that which provides (after required qualifications have been met), a sabbatical year for certain members or, as is granted in certain universities having the quarter system, a leave of absence with pay each eleventh quarter, this latter being given in addition to the usual yearly month's vacation. Such periods of study on salary would return these individuals to their work refreshed, enthusiastic and with a vision and understanding that would carry them far in the happy furthering of their individual work and that of the profession.

The second phase of staff education which I wish to stress is that which enriches the background of the nurse and helps her to a better understanding of life in general and of her function as a nurse in the community in particular. To me this education is quite as important, though the returns may be less tangible and require longer time for fruition. They may be of value in the length of the race if not in the perfection of the moment. And while we perhaps cannot expect the hospital to consider them of immediate economic value, I believe we should stress them equally. Any influence which improves the general cultural background of a professional woman

should also improve her attitude and efficiency in the profession. Such influences might include travel, reading, art, music, the concert, drama, and formal or informal class work of a specific or general nature.

First among these I should list the class given in Problems in Nursing by the Dean of the School which is open to faculty and supervisor members and to head nurses who have not registered for the classes in Ward Administration. In this class have been reviewed the outstanding problems in nursing today as well as many individual ward situations in the hospital. This class meets weekly on Saturday mornings from eleven to twelve.

A similar type of class is held for all the general-duty nurses, each member being required to read the report of the Grading Committee, "Nurses, Patients and Pocketbooks," and either to own or have access to a copy of the book. At first several manifested slight interest in the reading or the class, but as the weeks went by, the general-duty nurse with her red book under her arm became a familiar figure in the halls and corridors. Our goal has been that every graduate nurse and every Senior student nurse read "Nurses, Patients and Pocketbooks." In this connection should be mentioned a plan of study of this report suggested by a postgraduate student in a previous class. Her plan involved a Study Week in October, which should be made popular through the *Journal* columns and through letters sent to all schools of nursing and alumnae organizations in the country. During this week, nurses all over the country would be expected to join in a week's study of "Nurses, Patients and Pocketbooks."

The next phase of staff education, although perhaps in one sense a little technical for mention here, was of high background value—a perfectly splendid course in Hospital Administration which was given during the Winter Quarter by and under the direction of Dr. Malcolm T. MacEachern, Associate Director, American College of Surgeons. This was a major course, provided primarily for graduate students but taken also by many of the faculty, supervisors, and head nurses. It included such subjects as the following:

History of the American Hospital Association.
Hospital Construction.
Qualifications of Hospital Governing Body.
Duties and Relationships of Supervisory Staff.
Organization of a Medical Staff.
Open versus Closed Hospitals.
Method of Securing Best Doctors.
Case Records.
Business Management and Hospital Accounting.
Planning, Organization and Management of Centralized Services in Hospitals.
Hospital Standards.
The Organization, Management, and Administration of the Clinical Laboratory in the Hospital.
Organization and Management of an Out-Patient Department.
Ethics of Hospital Administration.
The Physical Therapy Department in the Hospital—Organization and Management.
Fundamental Considerations in Developing Social Service Work in Hospitals.
Organization and Management of the Dietary Department.

This course was given on the workers' own time, Monday and Wednesday evenings, from 7 to 9 p.m., and few were the evenings when members of the group were too tired to attend, or when they let other engagements prevent their coming.

Participation in the activities of nursing organizations, with the increased contact with nurses from other schools and localities, should widen the nurse's sympathies and engender in her a spirit of tolerance.

Mere attendance at meetings will present new ideas and varied methods of solving problems; taking a more or less active part in the programs will be even better. National, state, and local meetings frequently have as speakers, persons of prominence, significant in nursing and allied fields.

The First District Association of Illinois has moved into more economical living quarters, in order that, among other things, it may have available funds for bringing outstanding people and programs to its members. The Illinois League of Nursing Education has sponsored stimulating programs, and the Central Council for Nursing Education has brought in recent years such outstanding speakers as Mrs. Chester Bolton, May Ayres Burgess, Ph.D., Annie Goodrich, D.Sc., Dr. Haven Emerson, Dr. C.-E. A. Winslow, and Michael Davis, Ph.D. While it is true that many nurses never attend these meetings, it is encouraging to have an increasingly large number present.

The school within its program offers also major courses receiving university credit in sociology, psychology, and public hygiene. A few graduate nurses have availed themselves of the opportunity of taking these courses on their own time.

Other factors contributing to staff education in service are courses in universities. Numbers of our graduate nurses have enrolled in morning, afternoon, or evening classes, ward assignments being so arranged as not to conflict with class assignments for student nurses. Graduate nurses, therefore, taking permanent afternoon or night-duty assignments, are free to register for morning or evening classes. The variety of courses available is practically limitless, but among those subjects more directly applicable to nursing which have been taken are psychology, sociology, hygiene, the sciences, English composition, literature, pedagogy, and certain specialties such as physical therapy and laboratory technic.

In the larger cities supporting art institutes, schools of music and civic orchestras, there are many opportunities to enroll in courses in appreciation of art and music or to attend concerts and exhibits of rare beauty and quality. For those fortunate enough to possess some measure of ability along these lines, an avocation may be chosen in music, art, or many another interesting subject.

Summary

IT is perhaps difficult to state with definiteness all the ways in which staff improvement in service takes place. Much of it is a matter of such intangible values as atmosphere and personalities translated into terms of group coöperation and enthusiasm. But I have tried in this running comment to cover the definite ways in which these values are sought in the Illinois Training School for Nurses and to indicate certain other desirable measures.

To summarize briefly they may be enumerated as follows: First, those which we may call technical; second, those we may speak of as general. Of the first I have mentioned observation; routine reports; local, state, and national meetings; case studies; departmental conferences; group meetings or conferences; preparation of school publications; two-day teaching program, class demonstrations of introductory nursing procedures; revision of procedures; rotation of personnel; ward demonstrations; field trips; use of nursing journals; class in specialized treatments; class in ward administration; formal and informal instruction

of attendants; exchange of school personnel; and sabbatical year, or leave of absence with salary.

In the second are included the class for supervisors and head nurses in nursing problems; the classes for general duty nurses reviewing "Nurses, Patients and Professions"; the class in hospital administration; professional meetings; classes in psychology, sociology, and public hygiene at the school; and courses in art institutes and universities.

In conclusion may I emphasize that very desirable quality for any group—the quality of being interested in the work and plans of the organization and of having vision to carry on and carry out such a program? If we can keep alive in our groups the desire to do, to learn, and to improve in their work; to be happy in their learning, doing and improving; and to have a vision, without which any people perish, we shall then have done a worth-while task.

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DEPARTMENTAL CONFERENCE

November 17, 1926—Ward 51, 2 p.m.

Obstetrical Nursing

Postpartum Care of the Uterus:

1. Uterus after delivery.
   a. Consistency.
   b. Height.
   c. Size.
   d. Position.
2. Abdominal binder.
   a. Purpose.
   b. Kinds.
   c. Material.
   d. Application.
3. Breasts.
   a. Discussion of care following delivery.
   b. Nipples—kinds.
   c. Treatment.
   d. Simple engorgement—time—treatment.
   e. Binder—purpose—application.
   f. Ice bags—purpose—application.
   g. Compression binder—application.
4. Routine daily care of mother.
   a. Bath.
   b. Binder.
   c. Pads.
   d. Lochia.
   e. Irrigations.
      Kinds { Bichloride 1-2000. Lysol 3/4%. Sterile water.
      Demonstration with tray.
5. Charting.
   Breasts.
   Uterus—involution.
   Lochia—amount—character—odor.

Open discussion of subject.

Values of Play

IN addition to the basic value of offering relief from work tensions, of escape to freedom after the constraints of routine, we may mention on the physical side the marked development in motor control which has been shown to result when children are placed in a favorable play environment, and the skill in constructive planning and manipulation that proper play materials stimulate. Solitary play cultivates self-reliance, concentration, and lays the foundation for a resourceful use of leisure by the adult. Social play, on the other hand, teaches cooperation, ability to get on with others in the give and take of daily life. These two types of play are both necessary for the development of the child, and one should never be pursued at the expense of the other. Finally, play represents the ground from which all cultural life grows. The regulation of the appetites is important for health, and that we may be set free for these higher values which actually inhere in play. Happy the child whose play affords an early introduction to music, to art, to handicrafts, and to literature. The degree to which this happens will largely depend on the environment and opportunity which the parent supplies. To provide the right environment and leave the child a large measure of freedom in its use, is the part of wisdom.—From "Parents and the Pre-School Child," p. 126, Wm. E. Blatz. Publisher: Morrow & Co.

NATIONAL LEAGUE OF NURSING EDUCATION

LIST OF PUBLICATIONS, PHOTOGRAPHS, AND SLIDES

MAY BE PURCHASED FROM

370 SEVENTH AVENUE, NEW YORK, N. Y.

Adult Education	Charles H. Judd	$0.10
Bibliography (Text and Reference Books for Schools of Nursing)		.20
Challenge, A (Vocational Information on Nursing)	Postage charges only	
Choosing a Profession	Carrie M. Hall, R.N. per 100	1.00
Curriculum for Schools of Nursing, A, Education Committee, National League of Nursing Education		2.50
Distribution of Nursing Service in Hospitals	Marian Rottman, R.N.	.10
Hunting Nursing as a Profession	per 100	2.00
Education in Tuberculosis for Student Nurses	Louise M. Powell, R.N.	.15
Education of the Student Nurse in Tuberculosis Nursing, The	Katharine J. Densford, R.N.	.15
Forms of Government in Schools of Nursing	S. Lillian Clayton, R.N., and Others	.15
Furnishing and Equipment of a Residence for a School of Nursing	Alice Shepard Gilman, R.N.	.15
Goal of Nursing Education, The	Laura R. Logan, R.N.	.10
Habits and Skills	Maude B. Muse, R.N.	.10
Health Study in a Nursing School, A	Marian Rottman, R.N.	.10
How to Make General Duty More Attractive to Graduate Nurses, and Discussion	Anna D. Wolf, R.N., and Claribel A. Wheeler, R.N.	.15
Improvement of the Nurse in Service: an Historical Review.	Blanche Pfefferkorn, R.N.	.15
Investigation of Current Practice in Rating Ward Practice of Students in Schools of Nursing	Helen F. Hansen, R.N.	.15
M. Adelaide Nutting—Some Appreciations		.15
Mental Hygiene and the Student Nurse	Esther Loring Richards, M.D.	.15
Methods of Teaching Chemistry in Schools of Nursing	Harry C. Biddle	.10
Modern Facts and Phases of Tuberculosis	David Alexander Stewart, M.D.	.10
Nurse as a Teacher of Positive Health, The	Annie W. Goodrich, R.N.	.10
Nursing by Religious Orders in the United States	Ann Doyle, R.N.	
(As published monthly in the *American Journal of Nursing*) each		.15
Nursing Education in America: Review and Outlook	Laura R. Logan, R.N.	.10
Opportunities in the Field of Nursing (100 copies or over, 10 cents each)	Isabel M. Stewart, R.N.	.15
Organization and Management of a Nursing School Library, The	Blanche Pfefferkorn, R.N.	.10
Outlines of Courses in the Curriculum—Elements of Nutrition and Cookery, Elementary Materia Medica, Pediatric Nursing, and Case Study, each		.05
Out-patient Department as a Teaching Field for Student Nurses, The	Gertrude S. Banfield, R.N.	.15
Positive Health for Nurses	Caroline Hedger, M.D.	.05
Practical Values of Mental Tests and Measures in Schools of Nursing	Edith Margaret Potts, R.N.	.15
Preliminary Report of University Schools of Nursing, Education Committee, National League of Nursing Education		.20
Present Concept of Method, The	Georgina Lommen	.10
Problem of Making up High School Deficiency, The	Edith C. Richardson	.10
Problems Involved in the Grading Program	May Ayres Burgess, Ph.D.	.10
Problems of Professional Education	Samuel P. Capen, Ph.D.	.15
Proceedings of Conference on Nursing Schools Connected with Colleges and Universities, January, 1920		1.00
Relation of a School of Nursing to a Hospital, The	Isabel W. Lowman	.05
Report of the Committee on Budgets for Schools of Nursing, National League of Nursing Education		.10
Report of the Committee on Nomenclature, National League of Nursing Education		.05

Report of the Committee on Nursing Education	Josephine Goldmark	.10
Report of the Rockefeller Foundation on Nursing Education, The: A Review and Critique	Richard Olding Beard, M.D.	.10
Reports of the National League of Nursing Education—odd volumes, each		1.00
Routine Inspection of Schools of Nursing	Alma H. Scott, R.N.	.15
Some Essential Conditions in the Education of Nurses	M. Adelaide Nutting, R.N.	.25
Sound Economic Basis for Schools of Nursing and Other Addresses, A	M. Adelaide Nutting, R.N.	2.50
Staff Education for Institutional Nurses	M. Cordelia Cowan, R.N.	.15
State Registration Requirements for Entrance to Nursing Schools (Map)	per 100	1.00
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Taking Courage	Carrie M. Hall, R.N.	.10
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Tuberculosis among Young Women, with Special Reference to Tuberculosis among Nurses	Jessamine S. Whitney	.10
Very Small School of Nursing, The	Mary E. Gladwin, R.N.	.10
What Constitutes an Adequate Residence for a School of Nursing	Alice Shepard Gilman, R.N.	.10

LEAGUE CALENDARS AND BOOKLETS

Early Leaders of American Nursing, booklet 1922	$0.35
Leaders of American Nursing, booklet 1923	.35
Leaders of American Nursing, Calendar 1924	.50
Nurse in Poetry, Calendar 1926	.50
Hospital in Poetry, Calendar 1927	.50
Calendar of Quotations, 1928	.50
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Nursing and Nurses, Old and New, Calendar 1930	1.00

PHOTOGRAPHS

Florence Nightingale (2 styles)	$1.00 and $5.00
Linda Richards	5.00
Isabel Hampton Robb	3.50
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History of Nursing—189 in set—per slide	$0.50
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Life of Florence Nightingale—52 in set—per slide	.50
Rental by set (for one week)	5.00
History of American Nursing (in preparation, 65 slides have been collected) per slide	.50
Rental by set (for one week)	5.00

Transportation charges both ways are added to the cost of rental.
It takes about two weeks to fill orders for slides purchased.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Medical Social Work for Nurses

THE New York Chapter, formerly the New York County Chapter and the Bronx Chapter, has for the past few years been engaged in medical social service work for sick, ailing and needy nurses.

The work was started in 1917, operating through the Atlantic Division of the National Red Cross, when nurses were passing through New York to and from service abroad or in this country, many of whom were in need of special consideration of one sort or another.

With the closing of the Division Office this work was gradually assumed by the Chapter Nursing Service, the character of the work changing from one with military aspects to one incident to conditions in a great city with a large nursing population. New York, with its many hospitals and training schools, postgraduate courses, visiting nurse associations, etc., drawing nurses from all parts of the United States as well as foreign countries, has offered a fertile field for this restricted type of service.

Since 1924 it has been established as a definite service and allocated to the Nursing Service of the Chapter, which is directed by a Red Cross Nurse who is fortunate in having a Medical Social Service training. As the work has increased, two full-time, paid workers (Red Cross nurses) and one full-time nurse volunteer, have gradually been added to the staff. The following table indicates the character as well as the development in this highly specialized service. Figures are not available prior to 1925.

	1925	*1926*	*1927*	*1928*
Visits to sick nurses	833	2,132	4,449	7,539
Special visits	199	243	184	743
Special service		121	363	271
Nurses met and escorted	66	66	114	222
Nurses referred to other organizations	239	140	127	156
Interviews	1,291	1,260	1,418	2,224
Conferences		566	544	580

The territory is divided, each nurse visiting all the hospitals and other institutions in that area, as well as attending to all special calls and other questions that may arise in her respective territory.

In connection with this service the facilities of a Convalescent Home for Nurses at Babylon, Long Island, owned by the A. I. C. P., are utilized, as well as endowed beds for nurses at the Medical Center and elsewhere.

The Chapter has a special fund which provides flowers, fruit, delicacies (food) and small necessities. It is also occasionally drawn upon for railroad fares and necessary articles of clothing for a nurse who, having exhausted her funds, may be entering a sanitarium for treatment. Holidays and birthdays are given special attention, especially for the older nurses who, no longer able to work, may need a bit of cheer or for a "shut-in" who would find such occasions but "sad and sorry" ones if left alone. A lending library of books and periodicals, an important and popular feature, is maintained through gifts from friends and members of the Committee.

The sick nurse problem is a serious one, not only in New York but

practically everywhere. The "Grading Committee" through recent studies has discovered that the average amount earned by the private duty nurse (they form the largest group in the profession) is but slightly over $1,300 per year. They have also discovered that a very high percentage of these are carrying heavy family responsibilities, consequently many nurses are unable to save for the inevitable "rainy day."

The nurse with her professional training and rather high standard of living does not, for the most part, fall into the ordinary relief agency class. The work of the New York Chapter in this connection is not only appealing, but distinctly constructive in its character, as every effort is made to get the nurse back as promptly as possible to her normal position as a self-respecting, self-supporting citizen. This may mean securing her admission to a hospital, to a tuberculosis sanitarium, or to an institution for mental care. It may mean putting her in touch with some organization where she can secure a position, sending her to a convalescent home, or getting in touch with her alumnae association or friends to make such adjustments as are necessary.

While a very large proportion of the nurses assisted are members of the Red Cross enrollment, the work is not restricted to this class, for no nurse is turned away without some type of assistance. The amount of money spent upon the individual nurse is so small that it is almost negligible, the amount of time, interest and thought involved is difficult to measure in terms of hours.

The Executive Committee of the Chapter, or a Special Committee, and a Nurse Director, with social service training, are essential to the proper development of such a plan.

The success of this particular piece of work has been largely due to the unselfish devotion of such nurses as Mary Magoun Brown, Florence M. Johnson, Catherine Hay and Annie M. Thomas.

A suggestion has been made to other metropolitan chapters that a similar type of service might be rendered by them in their respective communities. In any case an unbroken field for a very interesting, as well as important, type of service is offered.

Reinstatement of Disenrolled Nurses

NURSES are sometimes disenrolled, because of our inability to obtain an annual questionnaire from them, and our lack of success in getting their present whereabouts through writing to their nearest relatives and training schools. If such, after seeing their name in the *American Journal of Nursing*, write to us, expressing an interest still in enrollment in the Red Cross Nursing Service, we carefully examine their papers to find out if they are still eligible. If they are over age or married, or were enrolled during the war and were not citizens of the United States, or if their training school did not meet our requirements, we explain to them that we cannot reinstate them unless they meet our present requirements for enrollment. If we find they are still eligible for enrollment, we insist upon a new application form and we secure a credential from their alumnae association, showing they are a member through alumnae and state associations of the American Nurses' Association. We have not been requiring a physical examination except in unusual cases where there had been a particularly flagrant neglect on the part of the nurse in never supplying

questionnaires and apparently deliberately failing to keep in touch with the Red Cross Nursing Service.

Expenditures for Disasters

RED CROSS nurses, particularly those who have assisted in disaster work, will be interested to learn that during the last fiscal year the American Red Cross administered the sum of $7,958,627 in aiding disaster victims. While the Red Cross calls only upon the public in outstanding calamities, it draws upon its own reserve funds, raised by membership fees, in its work in small disasters. For example, during the same period it expended from its own treasury $433,788 in relief of disaster sufferers.

The West Indies Hurricane of last September which devastated Porto Rico and a large part of Florida, was its greatest operation during the year. However, when this work closed in March it still had some twenty smaller disasters, chiefly from tornadoes and floods to care for.

If figures can tell a story, then the fact that the Red Cross has spent on an average during the last seven years, $927,000 annually out of its disaster reserve fund, in addition to an average annual expenditure of $6,750,000 in restricted funds, raised by public subscriptions, then a convincing and graphic picture is drawn. If for no other reason than this, every right thinking nurse will feel the necessity of renewing her annual membership.

Enrollments Annulled

THE enrollments of the following American Red Cross Nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters, and their return is requested when enrollment is annulled: Mrs. C. R. Archibald, *née* Agnes Swearingen; Lottie Viola Banker; Mrs. Agnes Irene Bartlett, *née* Kennedy; Mrs. J. D. Bateman, formerly Mrs. Maggie Bruce Hartronft; Mrs. Errol W. Beck, *née* Irene Haag; Mrs. Hilda E. Bedsole, *née* Kochendorfer; Mrs. Walter C. Bell, *née* Nellie Grace Pettifer; Mrs. Arthur E. Bence, *née* Clara Etta Beard; Mrs. Gerda H. Benta, *née* Clausen; Mrs. Melita Ingaborg Bentrott, *née* Carlen; Mrs. George A. Bisher, *née* Mary F. Hacker; Mrs. J. V. Blackman, *née* I. Bethel Beals; Marie Rose Bogard; Mrs. Josephine Boogrumnber, *née* Moore; Mrs. Charles Boozier, *née* Lucile Hixon; Flora L. Bradford; Mrs. William P. Brandt, *née* Clara Anna Reistroffer; Lydia Britton; Mrs. C. L. Brundage, *née* Flora June Mercer; Mary Anne Bullock; Mrs. N. H. Burkett, *née* Ruth Evelyn Baxter; Georgie Letitia Busby; Carmelita Calderwood; Mrs. Kathryn Carter, *née* Norton; Mrs. Gerald R. Carter, *née* Mamie Ansley; Frances K. Cavenaugh; Mary L. Cavenaugh; Helga Sigrid Christensen; Mrs. Frank J. Cihak, *née* Hulda Marion Teichman; Isabelle Connell; Mrs. George R. Cowie, *née* Myrtle Barnes; Mrs. L. J. Curley, *née* Bess M. Palen; Mrs. Helen May Cyre, *née* Hubacher; Mrs. Margaret Belle Dagnea, *née* Wallace; Mrs. Leo F. Davis, *née* Clara Mae Hagland; Mrs. Mabel Davis, *née* Alexander; Jessie DeWeese; Mary Elvira Dolan; Elizabeth B. Donoghue; Mrs. Myrtle Estella Drake, *née* Young; Ella M. Dressler; Cecelia Driscoll; Leona Vera Dunlap.

Correspondence Schools

" . . . It is possible to give theoretical instruction in nursing by correspondence, just as it is possible to give instruction in swimming on dry land. But after the motions have been learned in this manner, the only way to swim is to go into the water and acquire facility in performing them. Similarly the only way to learn the nursing art is by actually caring for the sick. Graduates of correspondence schools of nursing are just at the stage of entering the water."—"Medicine, Its Contribution to Civilization," Edward B. Vedder, The Williams & Wilkins Company, Baltimore, Md.

Student Nurses' Page

The Value of a School Publication

ISABEL BECK

Kahler Hospital School of Nursing, Rochester, Minn.

IN company with our contemporaries of other modern, up-to-the-minute schools, we of the Kahler School of Nursing believe in a school publication, and we have found its value to justify the expense and work entailed.

The primary purpose of a paper or magazine naturally should be to provide news of school events and interests. Thus, interest of students and alumnae is aroused, and a live organization results. What community, not dead from Main Street to the railroad tracks, would be without its newspaper? Why then should not a community of nurses have a publication to keep others interested in and informed of nursing and public hygiene?

The editorial staff should be composed of students who have willingness and ability for such work, assisted by a faculty advisor. This staff, in turn, solicits material and selects the best submitted, providing opportunities for those displaying a liking for journalism. Indeed, a second Mary Roberts Rinehart might arise to fame through having her literary efforts encouraged by her school paper.

An interesting paper brings a school under observation of worthy young women who might be planning to enter the profession, and in this way is an aid in increasing enrollment and improving the personnel of the school.

The reader might like to know how we of the Kahler School started and conduct our paper, *The Link*. It was first published in 1923 by a group of students and faculty who especially felt that the school needed a publication. It was named *The Link* to link the students to the interests of their school and its future. Published as a quarterly, it is edited by a staff composed of three members from each class, two alumnae, a faculty advisor, and one member with artistic ability. News items, social events, extra-curricular activities and editorials compose the content. A special effort is made to publish news of absent alumnae. Financial support is gained through subscriptions and advertising of local business concerns. The June issue, dedicated to the graduating class, is paid by the quarterly allowance and by the Seniors.

The following extract from a *Link* editorial: "What Is a School Paper?" gives our idea of the value of such a publication:

> It expresses the character, the culture, the tastes and ideals of its school and breathes its atmosphere.
>
> It is the only permanent record of the life of the school in all its phases and presents these phases in the most realistic manner.

It affords opportunity for the exercise and development of the best literary, business and artistic talent and gives expression to them.

It radiates and builds school spirit. It forms a connecting link between faculty, students, alumnae and patrons.

Self-supporting, it costs nothing.

It should contain just that desired combination of dignity and frivolity which gives it its position, not only in the school that sponsors it, but among that great yearly production of school publications.

Our Candy Shop

A STUDENT

St. Anthony Hospital School of Nursing, Oklahoma City, Oklahoma

ONCE upon a time there was a class of nurses who were very, very anxious to publish an annual. But there was a great big monster right in their path, and they did not know how to drive him away. Now this old bugaboo was Poverty. They had no funds, and they did not know how to go about getting any, for nurses are busy folks and don't have much time to spare. They gave a very clever little play which netted them $75, but when they shook this at the old monster, he only moved over an inch or two and gave them a sneering look, as much as to say, "What good will that do? It takes a lot of money for an annual." They took their superintendent of nurses into their confidence. There were various suggestions for investing the $75, and the result was that, after a few mysterious trips to the city, one of the little reception rooms in the nurses' home was locked up and, a day or two later, when the door was thrown open, there was the cutest little candy shop! Two library tables had been converted into counters, and on them was displayed a tempting array of sweets

(mostly five-cent-package goods), notebooks, pencils, pens, ink, and toilet articles.

It was a very attractive little shop, as the big comf'y chairs and divan had not been removed, and each evening one or more of the Senior nurses would bring their books or their sewing, and "keep store."

As the holidays approached, they bought some pretty, inexpensive Christmas gifts and cards, and it is surprising how popular the shop became among the student nurses; it simplified Christmas shopping so much! As time went on, showcases were purchased, with some money given the nurses as a Christmas gift, and the stock was gradually increased until it included most of the little trifles in every-day use. Altogether it has been a great success. The nurses like it because it saves them the trouble of running down town for every little thing and, besides, they know their credit is always good until the end of the month. The Superintendent likes it—let me just whisper this—because it keeps the nurses from congregating in the corner drug store.

While the bugaboo of providing means for publishing a yearbook has not been banished, it has at least been relegated to the background, as there really is quite a nice little income from our candy shop. Augmented by the proceeds of a play, a bridge party and advertisements, it helps greatly and so far we have not been obliged to discontinue our Annual.

A Correction

IN the August *Journal*, in an article entitled "A Basket-Ball League," by a member of the Philadelphia General Hospital Training School, it is stated that a cup is given the winner of a series of basket-ball games played by hospitals in Philadelphia, by the Women's Auxiliary of the American Legion. This cup was given by the Helen Fairchild Nurses' Post, No. 412, American Legion, not by the Legion Auxiliary. The members of the Helen Fairchild Post are members of the Legion by virtue of having served in the Army or the Navy during the War and having received honorable discharge.

Amy D. Swift, Adjutant, Helen Fairchild Nurses' Post, No. 412, American Legion.

Out of the Mail Bag

Of course I want the *Journal* to visit me many *egains*. I look forward to my copy and more than enjoy it. Having served in the Army Nurse Corps for four years, I find something for me in every article.

It would be very interesting to follow the *Journal* on some of its travels. I have read it in Siberia and the Philippines and my last copy was received at Hyannis State Normal School where it has attended a Summer Course in School Nursing for four years.

E. B. T.

Massachusetts

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 300 words; anonymous letters are not considered

A Porto Rican Commencement

SIXTEEN nurses! the largest group that has ever graduated from the Presbyterian Hospital at San Juan, Porto Rico, is a distinction enjoyed by the class of 1920.

The various events began with the Baccalaureate Service at the Union Church. The decorations were very effective, but the beauty of the service was the new white uniforms, the eager faces and bright eyes of the graduates. Class night with the usual stunts and songs and bedroom gifts was the next item, then Commencement! The reconstructed Presbyterian Church was an inspiration by itself, and the picture was quite complete when the staff of the hospital marched in at the head of the procession of students of the Training School. The uniforms demonstrated the years of service: the new white caps of the graduates, the blue dresses, white aprons and caps of the first- and second-year students, and those who had just entered the school with blue dresses and aprons, but without caps and bibs.

"La Mujer" (The Woman) was the subject of the discourse chosen by the native superintendent of the Protestant work in Porto Rico. His heart was in his message because of his interest in the hospital, in the class, in womanhood in every phase on the Island.

An impressive feature of the program was the scene of the graduates, standing with uplifted right hands, repeating with their instructor the Florence Nightingale pledge. When the school pin was given, the nurses were advised by the Superintendent of Nurses to wear it with reverence, since it bears the seal of the National Board of Missions and should typify that the young woman who wears it is not only a nurse but a torch-bearer, pledged to give of her best not only in her profession, but all through her life. As he handed each graduate her diploma, the Medical Director counseled each one to continue her studies, since it is by continual growth and improvement that she shall become a worthy member of her profession.

For the first time the Alumnae Association entertained the new class apart from the hospital, and when the unique idea of "A Rainbow" was presented, of course, interest was stimulated to breathless anticipation. The short speeches represented thoughts incited by the different colors of the rainbow: "Royal Purple," a King's daughter; "True Blue," loyalty and truth; "Freshness of Green," growth; "Orange," hopes for the future; "A Bouquet of Roses," the entire graduating class dressed in various shades of rose; and "The End of the Rainbow," the steady, persistent search for the most worthwhile things.

OLIVE SHALE.

San Juan.

Comments of an Observer

I AM not a nurse, but I am considerably interested in the subject of good nursing, and therefore would like to ask a few questions concerning this profession which is, I believe, one of the noblest callings of the day.

Is there a profession in the world that is more abused? One that allows more "quacks" to fill the ranks? Why is this? If this profession is worthy the name, why do not the nurses cooperate and do something about it? It is claimed that good nursing is of far more benefit in many instances than good medical treatment. Does the medical profession allow anyone who desires to pack a kit, and buy a few medical tools, to practice the art of medicine or surgery?

In the town in which I live we are overrun and flooded with so-called, practical nurses, and some of them go so far as to represent that they are registered nurses. This situation is demoralising the profession; it is putting the trained nurse out of business. These self-styled nurses will work "cheaper" than a trained nurse can, of course, because it has cost them nothing in time, money or effort to be a "nurse." Would we think for one minute of employing a one-year or a two-year medical student to care for us in an illness? Would the laws of our state or our land permit a student of medicine to care for the health of a person? Then why allow a person who knows nothing about nursing, "only what they have picked up," assume the responsibility? . . . Why will the doctors put their patients in the hands of these incompetent

women, when they can get the best at a few dollars more? Do they hold the life of their patients of so little value? What would these doctors say, and what steps would they take, if an interne of two days in a hospital would come out and locate in their territory and begin practice? Is not the organization of nurses at fault? . . .

Not long since I was talking with a doctor about this matter, and was speaking of the fine girls from our community that had taken up this work and put in their three years of hard work, asking him if he did not approve of the profession, and if he did not think some of these girls who carried their R.N. were not better equipped to serve him. He made the reply, "Well, you see, most of the people around here are not wealthy and do not feel they have means to employ a trained nurse." I asked him then how it was that they had means to employ a full-fledged doctor, why did they not employ an interne, or, better still, a medical student of one or two years of college work. This seemed to displease him.

There are no less than ten of this type of nurse in this small town of about 800, and we have at least eight fine girls that have spent three years of their lives in training, and not one of them can remain here and get work, on account of this other type of nurse. . . . Is this type of nurse cheap from the dollar standpoint? Are they not an expensive luxury? Often if a trained nurse was in charge, the patient would require their services for but a few days; and with this other type, it runs into weeks and sometimes months. Which are the more expensive? How long are the nurses going to sit tight and allow this situation to continue?

E. L. L.

New York.

Choose Your School with Care

IN my brief career as a graduate nurse, the many things that have come under my observation literally make me heartsick.

I was associated with a small hospital for some time, and here are some of the things that occurred while I was there: A student nurse was carried into police court for being in swimming nude with her men friends. A Senior nurse broke up a home, separating husband and wife; he was an ex-patient. This wife asked the nurse to leave her husband alone. The nurse was with the man in an automobile in front of the nurses' home, when the wife appeared on the scene and gave them both a walloping. Do you think for a minute that girl was expelled? She was given her diploma, instead, for the reason that the superintendent of nurses was going out several nights each week with a married man. The nurses in the hospital knew this, so nothing was done. Another nurse was delivered a few weeks after leaving the hospital.

What can you expect from our institutions like that? Instead of turning out nurses, you will turn out home-wreckers.

This matter was thoroughly discussed with the supervisors, and one or more said: "Well, nothing will be done about it," and come to find out these same supervisors were spending their week-ends on wild drinking parties.

As long as we say nothing and do less, these things will continue. Things like this should be exposed in every institution where they exist, and I for one shall do all in my power to eliminate and expose anything I see going on that is detrimental to the nursing profession.

R. V. J.

A Book Holder

I READ a request in the July *Journal* for suggestions for a book support for an invalid. In our hospital we use a glass table constructed like a bed table. A frame much like a picture frame, with a groove for the glass, is attached to four legs which are longer than the usual bed-table legs. The table stands directly over the patient's head, with the book turned down and read through the glass. To facilitate turning the pages, for the book must be slipped off and the pages turned, the top of the frame is omitted on one side which gives easier movement in handling the book. This is not too clear a description, but I think you can think it through. This table, of course, is for an invalid flat on his back.

R. L. S.

St. Louis.

Journals on Hand

MINNIE HOLLINGSWORTH, 424 South Church Street, Hendersonville, N. C., has the following *Journals* on hand which she will sell for fifteen cents a copy, plus postage: October, 1909, through October, 1910; October, 1912; December, 1912; January, September, October, 1914; October, November, December, 1916; 1917, complete; 1918, except July and November; 1919, except December; 1920, except November; 1921, February, March, May, July; May, 1922.

Anna S. VanKirk, 66 Ikeiku-dani, Tennoji, Osaka, Japan, will send to anyone who wishes to pay foreign postage, the following numbers of the *Journal*: 1920, September, November, December; 1927, January, February, November, December; 1928, January through June, and October through December; 1929, February.

Abstracts

Discussion of Use of Anesthesia in Obstetrics at Meeting of Section of Obstetrics and Gynecology of The Massachusetts Medical Society. (The *New England Journal of Medicine*. Massachusetts Medical Society, Boston, March 28, 1929.)

THE problem of diminishing or arresting pain during childbirth is one which has commanded the interest of the profession since the earliest times. At first some forms of alcohol chloroform and ether were resorted to, but these could only be used in advanced labor, during the second stage, and nothing was done for the long first stage which is so wearing, especially to the primipara.

In about 1908, morphine scopolamine narcosis was tried. In the early attempts, several doses of morphine were given with the result that many asphyxiated babies were born. In 1914, this technic was refined at Freiburg, and only the initial dose of morphine sulphate, grain 1/8, was given; the scopolamine hydrobromide, in doses of 1/200 grain, was repeated up to the point of amnesia. The method was tried in most American obstetric clinics, but was soon given up as a routine measure because of the danger to the baby.

What requirements are essential to an anesthetic agent in obstetrics? First, the agent must be safe for the mother and child; second, it must be capable of diminishing pain without arresting labor; and third, its method of administration must be simple so that it can be used in the home as well as in the obstetric clinic. We divide anesthesia in obstetrics into first stage anesthesia and second stage anesthesia.

First Stage Anesthesia.—At the beginning of the first stage, especially with the primipara, analgesia may be begun by the administration of a barbital preparation. Ipral, in a 2-grain dose, is a good preparation, since it causes but little depression. When labor is well established, with regular contractions, and the cervix about two fingers dilated, morphine sulphate, grain 1/6, and scopolamine hydrobromide, grain 1/150, are administered subcutaneously. The scopolamine hydrobromide may be repeated once or twice, in doses of grain 1/200, if the first stage is prolonged; the morphine is not repeated. This usually carries the parturient to the second stage with a fair degree of comfort.

Instead of the above, one may use morphine sulphate, grain 1/6, early in labor, followed by 20 or 30 grains of chloral hydrate administered rectally.

Second Stage Anesthesia.—During the second stage, gas and oxygen may be administered with each pain. Ethylene has been recommended for the same purpose, but has never gained much vogue because of its explosive properties. The actual delivery, whether normal or operative, is best carried out under ether anesthesia, as is the repair of the perineum when necessary.

Gwathmey's Synergistic Anesthesia.—With labor well established and pains coming at five-minute intervals and lasting forty seconds, a cleansing soapsuds enema is given. An intramuscular injection of 1/6 or 1/4 grain of morphine, depending upon the weight of the patient, and 2 c.c. of 50 per cent solution of magnesium sulphate is given deep into the gluteal region. Morphine sulphate, grain 1/4, is usually the proper dose, but in a small woman 1/6 grain is sufficient. Twenty minutes after the first injection, a second injection of 2 c.c. of 50 per cent magnesium sulphate is administered, whether the effect of the primary injection is sedative or not, as it tends to prolong the effect of the morphine. When the sedative effect of the morphine magnesium sulphate begins to wear off, usually in one to three hours, and when the parturient is about three fingers dilated, the ether rectal instillation is given through a suitable apparatus. This consists of a four-ounce funnel, attached to a twenty-inch length of rubber tubing, which is in turn connected by a glass connecting tip to a red rubber catheter, size 20 or 22, French. The rectal ether mixture has the following formula:

Quinine alkaloid, 20 grains.
Alcohol, 40 minims.
Ether, 2½ ounces.
Olive oil, enough to make 4 ounces.

This rectal mixture should be preceded and followed by an ounce of warm olive oil. A third injection of 2 c.c. of 50 per cent magnesium sulphate is now given to prolong the

action of the ether. The patient now is drowsy and sleeps lightly between pains, but consciousness is not entirely lost.

The rectal mixture may have to be repeated once or twice, at three-hour intervals; the mixture is the same, except that in the repeated doses, 10 grains of quinine alkaloid is used instead of 20 grains. Each repeated dose should be followed by the injection of 2 c.c. of 50 per cent magnesium sulphate.

A minimum of inhalation ether is needed for the delivery; gas, if desired, is safe, but chloroform should never be used. Harrar of the New York Lying-in Hospital has reported 5,500 such anesthesias without danger to the mother and child.

Recent articles have appeared recommending spinal anesthesia in obstetrics; the subject can be dismissed by stating that it is too dangerous a method to use in the ordinary case of labor.

Local infiltration anesthesia and paravaginal anesthesia, while safe, demand too exacting a technic to make them available in places other than the well-equipped maternity service.

Chloroform had a great deal of vogue some years ago. The dangers of this form of narcosis have been responsible for its elimination from obstetrics as well as from surgery.

Warning—Sanitary Pads Not Sterile

OUR attention has been called, from time to time, to the fact that sanitary pads, highly advertised and commercially available to everyone, are being used increasingly in connection with postpartum care under the mistaken impression, evidently, that they are sterile. The Division of Maternity, Infancy and Child Hygiene has taken this matter up with the scientific department of a surgical supply house which states that none of the pads commonly available in the drug trade have been sterilized because of the increased cost and because they are a highly competitive product.

Practically none of the pads in the open market are adapted for use in connection with surgical wounds or with the after-care of confinement cases. While they are clean, no doubt, they are not guaranteed as being sterile. Nurses and physicians should govern themselves accordingly.—*Health News*, New York State Department of Health, July, 1929.

Hitch Your Wagon to a Star

STUDENTS at the Orthopedic Hospital, Lincoln, Neb., have developed a poster with the caption "Hitch Your Wagon to a Star." The wagon is shown with tact and honesty as fundamental nursing motives. Beneath it are tabulated many of the desirable traits and, as the hitching rope rises ever higher toward the star, the ideal nurse, we find respect for authority, a comprehension of the real patient and emphasis on intelligent rather than mechanical service. Such a poster might be worked out by any class in ethics.

Journals Wanted

WILL any nurse who is willing to pass on her copy of the *Journal* each month, please send her name to the *American Journal of Nursing*, 370 Seventh Avenue, New York. There are several nurses who are ill who would like to see the magazine and there are also foreign nurses, graduates of the International Course in London, who would greatly appreciate receiving copies regularly. The *Journal* would like to have at least ten names of subscribers who can be depended upon to send on their *Journals* regularly, each month.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Nurses' Relief Fund

REPORT FOR AUGUST, 1929

Receipts

Interest received on investments	$45.00
Interest received on bank balances	15.75

Contributions

California: State Nurses' Association	122.00
District of Columbia: Georgetown Hospital	17.00
Iowa: Dist. 2, Individual member, $1; Dist. 3, Mercy Hospital Alumnae Assn., $15; Dist. 4, $14; Dist. 6, St. Luke's Hospital Alumnae Assn., $80	95.00
Kansas: Halstead Hospital Alumnae Assn.	10.00
Minnesota: Dist. 3, Individual member, $2; Northwestern Hospital Alumnae Assn., $5; Asbury Hospital Alumnae Assn., $4; Fairview Hospital Alumnae Assn., $5; Deaconess Hospital Alumnae Assn., $1; Individual members, $3	16.00
New Hampshire: Hasbro Memorial Hospital Alumnae Assn.	7.50
New Jersey: Dist. 2, Bayonne Hospital Alumnae Assn.	10.00
New York: Individual contribution	9.00
Texas: District 16	2.00
	$349.25

Disbursements

Paid to 101 applicants	$2,757.00
Salaries	294.16
Printing	19.44
Custodian fee	64.00
Review of case records	135.00
	$3,229.60
Excess of expenditures over income for month ending August 31, 1929	$2,880.35

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman or the Director of the American Nurses' Association headquarters, 370 Seventh Avenue, New York, N. Y.

The Northwest Division

The convention of the NORTHWEST DIVISION of the American Nurses' Association opened July 24, in the Palm Room of the Rainbow Hotel, Great Falls, Montana, following a half-day session of the Montana State Association of Graduate Nurses on July 23. Registration totalled one hundred and sixty.

Morning session, the President, Augusta Arins, presiding: Invocation, Rev. E. R. Todd; addresses of welcome, J. W. Freeman, President Chamber of Commerce; Mrs. Reynald Dahl, President of District No. 6; Sister John Gabriel of Seattle; Response, Mrs. C. J. Kepper, State Examining Board. Reports from the state associations were given by Mrs. Spry for Washington, Miss Gavin for Oregon, Mrs. Morris for Montana. Greetings from guests were given by Sister John Gabriel; Mrs. Alma Scott, representing A. N. A. Headquarters; Anna Jammé of California; Henrietta Adams from the University of Washington, Seattle; Clare DeCou, the Navy Nurse Corps. An address, "Nursing Education from the Physician's Viewpoint," was given by Dr. Alfred; and a film, "Life of Pasteur," was shown.

At the *afternoon session*, Henrietta Adams presided and the program included: President's address, Augusta Arins; "Our Changing Outlook," Anna C. Jammé; "Newer Knowledge of Nursing Education," Henrietta Adams; "We Are What Our Glands Are," Dr. Hitchcock; "Education of Adults," Sister Gabriel; address by Mrs. Alma H.

Scott; "The Nurse as a Citizen," Sister Gabriel.

Following the adjournment members of the convention enjoyed a trip through the wire mills and later a picnic at Big Falls, provided through the courtesy of the Anaconda Copper Mining Company.

July 28, Morning Session, Anna C. Jammé presiding; "Osler's Philosophy of Life," Ward Boyd, M.D.; "Care of the Obstetrical Case," Dr. T. Williams; "A. N. A. Headquarters," Mrs. Alma H. Scott; "Nursing in the Navy," Miss DeCou; "Nursing in National Parks," Laverne Fitzgerald.

The meeting was adjourned for luncheon which was given at the Rainbow Hotel by District No. 6. During this time the movie film, "The Intestinal Tract," was shown.

At the *afternoon session*, Sister Gabriel presiding, the addresses were: "Community Organization for Health Work," Thomas Walker, M.D.; "The Common Cold," illustrated with slides, C. F. Coulter, M.D.; "The New Frontier," Dr. Maybelle True; "Teaching the Nurse Dietetics," Elizabeth Yates; reports of the International Congress, Sister Gabriel and Mrs. Scott.

A motion to appoint a committee to study laws which provide for examination and registration of nurses in the Western States, with a view to standardization, was made by Miss Phelps, Portland, Ore. The following committee was appointed by the President: Grace Phelps, Portland; Jane Gavin, Portland; Miss Linfield, Bozeman. Committees appointed by Miss Arim, the President, were: Nomination of Officers, Mrs. Spry, Tacoma; Miss Phelps, Portland; Miss Stout, Sidney. Resolutions, Miss Gudmunsen, Butte; Miss Gavin, Portland; Miss Gillespie, Seattle.

The Nominating Committee submitted names of the following who were elected unanimously: Mrs. Elizabeth Scuis, Seattle, President; Emily Fine, Boise, vice president; Katherine Leahy, Seattle, secretary; Mrs. Ida Napper, Butte, treasurer.

The Resolutions Committee, acting with the committee of the Montana State Association, submitted resolutions recommending that the remaining states of the Rocky Mountain Division and Pacific Coast be invited to join the Northwest Division; also expressing gratitude to District No. 6 of the Montana State Association of Graduate Nurses, the Montana Power Company, the Anaconda Copper Mining Company, the Rainbow Hotel, the Cascade County Medical Association, the Chamber of Commerce of Great Falls, and to the Press. Embodied in the resolutions and conformed to by those present, was a moment's silent prayer to the memory of Dr. Hazel Dell Bunnell.

Nurses attending the convention, from Seattle, extended the invitation to meet in their city in 1931. The invitation was accepted. It was decided that $100 be drawn from the treasury to be paid to District No. 6 of the Montana State Association to help defray the expenses of the convention. The meeting adjourned and practically all who attended were entertained at a picnic supper at Memorah. The guests who so ably helped with the program were appreciated and enjoyed.

The Southern Division Conference

All members of the A. N. A., and Southern nurses particularly, will be interested in the initial meeting of the Southern Division, to be held in Birmingham, Ala., October 28-30. Eleven states will be represented, including Georgia, Florida, North and South Carolina, Virginia, Kentucky, Tennessee, Alabama, Mississippi, Louisiana and Texas, and should bring together a large and representative group of nurses to participate in what is expected to be a very helpful conference. Oklahoma, the twelfth state, will be unable to send representatives to the New Division this year. Jane Van De Vrede, President, will preside.

The program has been arranged along conference lines rather than that of a formal convention, to coincide with the purposes for which Division organizations were created by the American Nurses' Association. It will include regular sessions to be given over to both national and sectional leaders who will bring their interpretation of some of the urgent problems in nursing.

Alabama nurses have sacrificed all social features of their own annual meeting, and have liberally prepared for the comfort, welfare and entertainment of the guests of the Southern Division. Beginning on Sunday afternoon, October 27, the Birmingham nurses will pour tea at their new club house, and throughout the duration of the conference will provide many pleasurable innovations for the visitors.

Convention headquarters will be in the Tutwiler Hotel. Registration of delegates will begin at 9 o'clock, Monday morning, October 28. A registration fee of $1 will help to defray conference expenses.

The president of the Jefferson County Medical Society will welcome the visitors to Birmingham. A roll call by states, minutes

and reports of officers, and adoption of constitution and by-laws for the Division, will constitute the main features of the first session. An old-fashioned barbecue will follow. This is to be tendered by the members of the Jefferson County Medical Society. Janet M. Geister, Director at Headquarters of the A. N. A., will make the chief address at the afternoon session on Monday, discussing A. N. A. policies and program, and allowing ample time for discussion and questions. A sight-seeing tour of Birmingham and environs has been arranged for late Monday afternoon, to be followed by a buffet supper at St. Vincent's Hospital. The evening session will include addresses by S. Lillian Clayton, President of the American Nurses' Association, Adda Eldredge, Director of the Bureau of Education, State Board of Health, Wisconsin, and the President's message, in addition to a ceremonial by states, prefaced by addresses of welcome by the Mayor of Birmingham and by Annie Reddoy, President of the Alabama State Nurses' Association, with response by A. Louise Dietrich, Treasurer of the Southern Division, General Secretary of the Texas State Association, and a member of the Board of Directors of the A. N. A.

Tuesday morning, Mary M. Roberts, Editor of the *American Journal of Nursing*, will give an address. Louise Oaten, B. S., M. A., Director of the Department of Nursing of the University of Virginia, will present "Opportunities in Education for Southern Nurses," which will be contributed to by a number of state leaders. Anne C. Williamson, Fort Benning, Ga., will present the program of the Army Nurse Corps. Group luncheons will follow. The Tuesday afternoon session is to include a presentation by Miss Clayton of the Harmon Plan for Annuities for Nurses, and an address by Dr. A. L. Lenna of the Metropolitan Life Insurance Company. The Women's Auxiliary to the Jefferson County Medical Society will entertain the members at a tea at the close of this session, and a banquet at the Tutwiler will take place in the evening. Jessie Mortimer, Director of the Bureau of Child Hygiene and Public Health Nursing for Alabama, will be toastmistress.

Ethel Smith, Secretary of the Virginia State Board of Examiners of Nurses, will present the mutual problems of Boards of Examiners at the Wednesday morning session, and will be assisted by the secretaries of the several states represented. This session will be shared by the Nursing Service of the American Red Cross, and Ida C. Butler, Assistant to the Director of Nursing Service, National Red Cross, will be the main speaker. Clara Dunn and Ruth Mettinger, nursing field representatives, will also have a part. Reports of State Committees will be given, and a Red Cross luncheon to which all Red Cross nurses may come will follow. A brief business session will close the conference Wednesday afternoon, October 30, at which the president for the next biennium will be chosen.

A Joint Project in Social Hygiene

The National Organization for Public Health Nursing and the American Social Hygiene Association have undertaken a joint project, the purpose of which is to further the contribution of public health nursing agencies to the social hygiene program. Edna L. Moore, a graduate of the Toronto General Hospital, will be added to the staff of the N. O. P. H. N. to engage in this work.

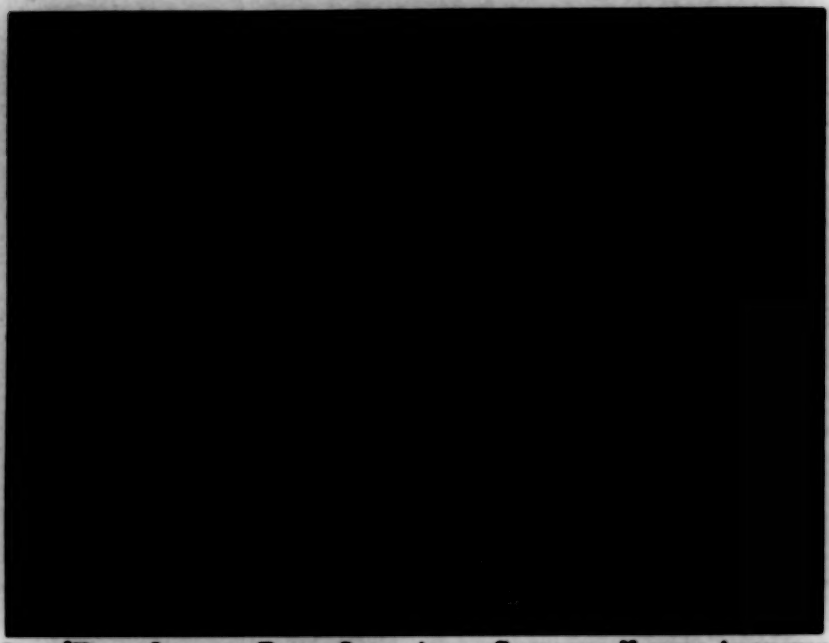
National Association of Colored Graduate Nurses

The twenty-second annual convention of the NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES was held in New York City, August 19-23, with headquarters at the Young Women's Christian Association on West 137th St. Two hundred and fifty members were registered for the most successful meeting the Association has ever held. The program was as follows:

August 19, Registration, and meeting of the Executive Board.

August 20, Section on Postgraduate Education, Carrie E. Bullock, presiding; the speakers being Belle Davis, Myrtle M. Patten, Agar Bosser and E. Porter Phillips. Hospital Section, Lulu G. Warlick, presiding. "Supervision of Nurses," Charlotte E. May; "Charting," Alice Gentry; "Extra-Curricular Activities," Gertrude Nicholas; "General Planning in Hospitals," Hubin Little; "Stimulating Interest among Students in Curricular Activities," G. Estella Massey. 4 p.m., tea served by Freedmen's Nurses' Club of New York. 8 p.m., public meeting at St. Mark's Church, Mabel Doyle Keaton, presiding; invocation, Rev. John W. Robinson; addresses of welcome, Mayor Walker, Alderman Fred Moore, May E. Chinn, M.D., Jean Ready; president's address, Carrie E. Bullock.

August 21, reports of committees; review of



PUBLIC HEALTH LUNCHEON, TWENTY-SECOND ANNUAL CONVENTION, NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES

"Path Finders," Meta Pennock; public health luncheon, Marion J. Pettiford, presiding; subject for discussion, "Adapting the Negro Nurse to a Public Health Program," led by Lillian J. Wald, followed by Amelia E. Grant, Payton F. Anderson, M.D., and Roscoe C. Brown, M.D. Tour of the Dunbar Garden Apartments.

August 22, a business session, followed by one at which Mrs. Thoms presided. Mrs. Alma H. Scott, Field Secretary, American Nurses' Association, discussed "Problems of the Private Duty Nurse" from a general standpoint; Ruby Burke, presented "Some of the Special Problems of the Private Duty Nurse." A paper, written by Jeanette O. May, was read in which the importance of employment of a field worker for the National Association of Colored Graduate Nurses and the advisability of cooperation of this association with the American Nurses' Association were emphasized. Dr. Curtis Sheets of Freeport, Long Island, pointed out the value of efficient nursing service to the general practitioner. Mrs. Jessie Sheet Stokes gave an interesting summary of her work as a social service nurse in New York City; she was the first social service nurse appointed by a Charity Association in New York and her work started in 1902. Rev. John W. Robinson spoke concerning the opportunities for service that are constantly confronting the nurse. The afternoon session was held in the auditorium of the Lincoln Hospital School for Nurses, Lula G. Warlick, presiding. Rita E. Miller spoke on "Teaching Anatomy and Physiology in Schools of Nursing," A. Pauline Glenn on "Nursing on a Medical Ward," and Mrs. Mabel C. Northcross, on "Surgical Nursing," illustrating her method of teaching this subject by use of an exhibit of various types of surgical dressings and miniature copies of the several articles of linen used in the operating room. A tea followed the afternoon session.

August 23, morning, a business session. The afternoon session was held in the Henry Street Administration Building, Marion J. Pettiford, chairman. Dora M. Cornelison, Field Representative of the *American Journal of Nursing*, spoke on "Newer Developments in Nursing Education." A reception was held in the evening at Renaissance Hall.

Officers elected are: President, Hallie Q.

Avery, Memphis, Tenn.; vice presidents, Mrs. Mabel Doyle Keaten of New York and Mrs. Mary Beets, Tuskegee, Ala.; recording secretary, Mrs. Eva Simpson Waters, Galesburg, Ill.; corresponding secretary, Mrs. Daisy Dickerson, Chicago; treasurer, Petra Finn, Greenville, S. C.

Army Nurse Corps

During the month of August, 1929, orders were issued for the transfer of members of the Army Nurse Corps to the stations as indicated: To Fort Eustis, Virginia, 2nd Lieut. Ethel E. Peters; to Letterman General Hospital, San Francisco, Calif., 2nd Lieuts. Florence M. Bailly, Josephine Kennedy, Vivo B. Brinkley; to Fort Monroe, Va., 2nd Lieut. Ruth E. Parsons; to Fort D. A. Russell, Wyo., 2nd Lieut. Rose M. Stringfellow; to Fort Sam Houston, Texas, 2nd Lieuts. Emily L. McLean, Bertha Tuell, Estella P. Pahl, Louise Miller, Evelyn B. Pahl, Katherine Burns, Sayde Rosenthal, Margaret F. Riley; to Walter Reed General Hospital, Washington, D. C., 2nd Lieut. Stella E. Williams, Anna L. Hart, Christina C. MacLauchlan.

Thirty-eight have been admitted to the Corps, as 2nd Lieuts.

The following named, previously reported separated from the Corps, have been reassigned: Miriam Schmuehli, Letterman G. H., San Francisco, Calif.; Ruby Mae Mahon, Station Hospital, Fort Banks, Mass.; Ruth M. Bennett (formerly Ruth E. Metcalf), Station Hospital, Fort Sam Houston, Texas.

The following named are under orders for separation from the Corps; Catharine J. Finn, Florence M. Harvey, Coralie West, Mary B. Van Riper, Zoe Ellen Knowles, Marie J. McAsey, Aurora Rue, Mary E. Ferris, Margaret F. Benelin, Dorothy M. Clark, Myrtle Dubdy, Louise E. Gans, Florence M. Jones, Ruth E. Martin, Lillian M. Cook, Carrie T. Rowland, Addie Belle Townsend.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of August nine nurses have been appointed and assigned to duty.

Transfers: To Annapolis, Md., Annie Bovaird; to Canacao, P. I., Rose E. Walker; to Chelsea, Mass., M. Winifred Marsh; to Mare Island, Calif., Mary F. Spencer; to Newport, R. I., Mary Peoples; to New York, N. Y., Agnes M. Byrne; to Norfolk, Va., Ruth Murray; to Parris Island, S. C., Mary Hennemeier, Anna L. Merritt; to Pensacola, Fla., Agnes J. Gibson; to St. Thomas, V. I., Helen Mason Ernest, Mary Louise Kelley; to San Diego, Calif., Hospital Corps Training School, Florence I. Meagher; to San Diego, Calif., Sibyl M. Ackley, Virginia A. Rau; to U.S.S. *Relief*, Elizabeth M. O'Brien; to Washington, D. C., M. Nirvinia Bailey, Adah L. Farnsworth, Mina A. King, Chief Nurse; to Washington, D. C., Dispensary, Navy Department, Lula Lloyd.

The following nurses have been separated from the Service: Juanita Duty, Alma M. Painter, Marian H. Clapsadel, Agnes Pugh.

J. BEATRICE BOWMAN,
Supt., Navy Nurse Corps.

U. S. Public Health Service, Nursing Service

The following new assignments, transfers, and reinstatements have been made in the U. S. Public Health Service during the month of August, 1929:

New Assignments: Thirteen.

Transfers: To Buffalo, N. Y., Ellen Rae Leonard; to Fort Stanton, N. M., Rose Mae Vann; to Stapleton, N. Y., Ida Syse; to Port Townsend, Wash., Ada McCool; to Angel Island, Calif., Agnes Corcoran; to San Francisco, Calif., Mary Russell.

Reinstatements: Gladys Varner, Susan Rudden, Alice Elliott.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

REPORT OF NURSING SERVICE

On July 12, the Director of this Bureau approved:

1. The establishment of a formal course for attendants, to better prepare them to render more intelligent and acceptable service to the patients of the Bureau.

2. A formal program of staff education in Psychiatric Nursing to be initiated in all the hospitals of the U. S. Veterans' Bureau,—special postgraduate courses to be made available for the nurses in the service.

During the month of August, 1929, orders were issued for transfer of the following named nurses: To Northport, L. I., New York, Carrie Kolarik; to Perry Point, Md., Marion

Echternach; to Castle Point, N. Y., Agnes Hanrahan; to Outwood, Ky., Sally Whitmarsh; to Whipple, Ariz., Ruth Cottrell; to Northampton, Mass., Mary Fagan.

The following were reinstated: Lucille Rhoades; Amy Schreiber; Marguerite M. Israel; Mary B. Sloan; Anna C. Holliday; Marion Flahive; Rita M. Huff; Anna Kovic; Ellie Brooks; Ida Peshkee; Hannah Flahive; Margaret McGeal; Marie J. Taylor.

Twenty-eight new assignments were made.

The following nurses have been separated from the service: Cora Sarvis; Lucille Mulvehill; Martha B. Allen; Margaret Griffith; Ingie M. Butler; Fay Simmons; Alice Gorman; Catherine Prudhour; Ellison Sward, death (accident); Edith Nichols; Grace Harris; Hilda Nutter; Alpha Rhian; Lillian Hill; Ethel Smith; Catherine Clarkson; Rose Avery; Alice G. Armstrong; Mildred Stewart; Katherine Murphy; Margaret Gearin; Lila O. Neal; Lillian Hayne; Margaret Taylor; Olive R. Turner; Catherine W. Dillahunt; Patricia Noonan; Mildred Ode.

MARY A. HICKEY,
Supt. of Nurses, U. S. V. B.

American Dietetic Association

The twelfth annual meeting of the American Dietetic Association will be held in Detroit, Mich., October 6–11, with headquarters at the Statler Hotel.

The exhibits and many of the addresses will be of interest to nurses.

Institutes or Special Courses

Ohio: The JOINT INSTITUTE OF THE SECTIONS ON EDUCATION, PUBLIC HEALTH AND PRIVATE DUTY NURSING of the Ohio State Nurses' Association will be held October 31, November 1 and 2. Headquarters for the Institute will be Hotel Statler, Cleveland. There will be a group of lectures emphasizing "Psychology," and demonstrations in nursing technic will also be given.

Tennessee: An institute for nurses will be held at the Andrew Jackson Hotel, Nashville, October 16–19, following the State Convention.

The subjects are of vital interest to nurses in all fields. They are as follows:

1. Principles of Learning: A four-lecture course, Dr. Joseph Peterson, Chair of Psychology, George Peabody College for Teachers.
2. Mental Hygiene: A four-lecture course.
   (a) Body—mind relationship.
   (b) Illness—a process of both mind and body.
   (c) Mental nursing.
   (d) Mental hygiene—general, school, community—Margaret S. Bolyen, Superintendent of Nurses, the Sheppard & Enoch Pratt Hospital Nursing School, Towson, Md.
3. The Nurses' Part in Modern Health Crusade: A four-lecture course.
   (a) Cancer Prophylaxis, Dr. John C. Burch, Instructor of Clinical Gynecology, Vanderbilt University.
   (b) Tuberculosis Prophylaxis.
   (c) Prevention of Infections of Children. Dr. Horton R. Casparis, Professor of Pediatrics, Vanderbilt University.
   (d) Prophylaxis of Focal Infections, Dr. Guy A. Manson, Instructor of Ophthalmology, Vanderbilt University.
4. Sociology: A four-lecture course, covering characteristic problems that are met by health agencies and how these agencies aid in adjusting them.
5. Vitamins: A four-lecture course, Mary P. Wilson, Home Economics Department, Peabody College.
6. Demonstrations and Drills (Handwashing, Equipment for Hot Lunches for Rural Schools, etc.) Elma Reed, Associate Professor, Department of Nursing Education, George Peabody College for Teachers.
7. Three evening lectures:
   (a) Therapeutic and Prophylactic Use of Sera and Vaccines, Dr. Casparis.
   (b) The Value of Nursing Organizations to the Nurse.
   (c) Suggestions for meeting conditions of nursing as presented in "Nurses, Patients and Pocketbooks," Julia C. Tebo, Secretary State Board of Nurse Examiners of Louisiana.

The tuition fee is $10. Further information may be obtained from Hazel Lee Goff, Chairman, Riverside, Ft. Sanders Hospital, Knoxville.

State Boards of Examiners

District of Columbia: The NURSES' EXAMINING BOARD OF THE DISTRICT OF COLUMBIA

will hold an examination for the registration of nurses on November 5 and 6, 1920, at the Franklin School, Washington. All applications for registration must be in the hands of the Executive Secretary not later than October 15. Bertha E. McAfee, Executive Secretary, 1327 K St., N.W., Washington.

Kentucky: An examination for graduate nurses will be conducted by the KENTUCKY STATE BOARD OF NURSE EXAMINERS, in Louisville, on the 19th and 20th days of November, 1920. All necessary information and applications may be secured by writing to Flora E. Keen, Secretary, Thierman Apt. C-4, Louisville.

Louisiana: The next examination of the Louisiana Nurses' Board of Examiners will be held in New Orleans and in Shreveport, November 12 and 13, 1920. For further information, address Julia C. Tebo, Secretary, 1026 Pere Marquette Building, New Orleans.

Maine: The MAINE STATE BOARD OF NURSE EXAMINERS will hold an examination, October 16 and 17, at the State House, Augusta. Theresa R. Anderson, Secretary.

New Mexico: The NEW MEXICO STATE BOARD OF NURSE EXAMINERS will hold examinations at St. Joseph's Sanatorium, Albuquerque, November 14, 1920. The Board will meet on November 23, in Santa Fe, to approve applications. The officers of the Board are Sister Mary Lawrence, of St. Joseph's Sanatorium, Albuquerque, New Mexico, President; and Ella J. Bartlett, 1601 East Silver, Albuquerque, secretary-treasurer.

Oregon: The OREGON STATE BOARD FOR EXAMINATION AND REGISTRATION OF NURSES will conduct an examination, for applicants desiring to register, in Portland November 7 and 8, 1920. No applications will be accepted after the 19th of October. For further information write Grace L. Taylor, Secretary, 448 Center St., Salem.

Rhode Island: The RHODE ISLAND BOARD OF EXAMINERS OF NURSES will hold its examinations November 14 and 15, 1920, at 9 a.m. in the Museum of the Rhode Island College of Education. Evelyn C. Mulvenan, Secretary, St. Joseph's Hospital, Providence.

West Virginia: The WEST VIRGINIA STATE BOARD OF EXAMINERS FOR REGISTERED NURSES will conduct an examination Monday, October 21, at the Ohio Valley General Hospital, Wheeling, and at the New Charleston General Hospital, Charleston. Frank LaMoyne Rupp, M.D., President; Mrs. Andrew Wilson, R.N., secretary-treasurer.

State Associations

Alabama: The ALABAMA STATE ASSOCIATION will hold its annual meeting on October 28, in connection with the meetings of the Southern Division, in Birmingham.

Arkansas: The ARKANSAS STATE NURSES' ASSOCIATION will hold its seventeenth annual meeting in Little Rock, November 4 and 5, with headquarters at Hotel LaFayette. All nurses throughout the State are urged to attend.

California: The annual meeting of the CALIFORNIA LEAGUE OF NURSING EDUCATION was held in Sacramento, on June 19, Mary M. Pickering, presiding.

At the regular business meeting, reports of Section chairmen, officers and committees were given. Slight revisions in the by-laws, approved by the National Committee on Revisions, were adopted. The morning program covering the subject of Clinical Instruction was presented in the following papers: "Cooperation between Faculty and Graduate Staff," Helen A. Sparks, Sacramento; "Case Work," Mildred Butler DeLay, St. Helena; "The Bedside Clinic," Edith Margaret Potts, Pasadena. (Paper read by Ethel Swope.)

A study of Grading Practice in Nursing was the subject of the afternoon program. The following papers were presented: "A Study of Current Methods in Rating," Helen F. Hansen, Assistant Inspector, Bureau of Registration of Nurses; "The Effect of Use of Rating Scales on the Quality of Nursing Service," Mabel I. Laur, Alta Bates Hospital School of Nursing; "Opportunities for Growth of Students and Staff by the Use of the Rating Scale," D. Dean Ureh, Highland Hospital School of Nursing.

The general session was held in the auditorium at 8 p.m., when Miss Pickering gave the address of the evening; her subject, "The Junior College as a Factor in Nursing Education."

A feature of the convention was the attendance of approximately eighty-five members of the California Association of Student Nurses. Their annual meeting was held during the morning in Memorial Hall, Inez Langtwait, the State President, presiding. Reports of officers and committees were given. Revisions in the by-laws provide for a per capita membership fee of 25c for each school whose students are members of the Association. The students visited local hospitals, the municipal clinic, and other points of interest during the afternoon. The annual banquet was a pleasant affair, held in the Senator

Hotel at 6 p.m., the group later attending the general session of the League to hear Miss Pickering's address.

At the close of the general session, brief reports were made of the California schools of nursing having Junior College affiliations. The meeting concluded with the reading of the tellers' report.

Florida: The FLORIDA STATE NURSES' ASSOCIATION will hold its annual meeting in Ocala, November 5–7, at the Marion Hotel. A meeting of the Board of Directors will be held at 10 a.m., Tuesday, November 5. In the afternoon, at 2, there will be an opening session with an address of welcome by the Mayor of Ocala. At 4.30 there will be a tea sponsored by the pupil nurses of the Marion General Hospital.

November 6, 7.30 a.m., registrar's breakfast. 9.30 a.m., Public Health Section, Mrs. Nancy Lawlor presiding. 12.15, Public Health nurses' luncheon. 2 p.m., Private Duty Section with an address by S. Lillian Clayton, President of the American Nurses' Association. 4 p.m., trip to Silver Springs and a dinner.

November 7, 9.30, Red Cross Section, Mrs. A. A. Lambert, State Chairman, presiding. Ida F. Butler, Assistant Director, Nursing Service American Red Cross, will be the principal speaker. 12.30, Red Cross luncheon. 2 p.m., business session. 8 p.m., moving pictures.

The Marion Hotel will be headquarters. Rates: Single rooms with bath, $2.50 and $3; double room with bath, $4 and $5. Make reservations early. Mary Marshall is Chairman of the Program Committee; Irene Sutton is Chairman of the Arrangements Committee.

Georgia: The GEORGIA STATE NURSES' ASSOCIATION will hold its annual meeting in Rome, October 30–November 2, at the Hotel General Forrest.

Illinois: The twenty-eighth annual convention of the ILLINOIS STATE ASSOCIATION OF GRADUATE NURSES will be held in Moline, October 10, 11, and 12, with headquarters at the Le Claire Hotel. The program is as follows:

October 9, 5.30 p.m., directors' dinner and meeting, to be held at the Golf Club, Rock Island Arsenal, Rock Island, Ill.

October 10, 8.30–10 a.m., registration. 9.30–10.30, opening session, Gold Room, Le Claire Hotel, May Kennedy, President, presiding; invocation, Rev. W. X. Magnuson; addresses of welcome, Mayor C. W. Sanderson, Dr. Karl Wahlberg, and Mrs. Alma Kronholm, President of the Fifth District; response and President's address, May Kennedy; 10.30–12, business meeting. 12.30 p.m., luncheon and business meeting, Illinois League of Nursing Education, Evelyn Wood, President, presiding. Thursday afternoon, all meetings in charge of the Private Duty Section; Blanche Hansen, Chairman, presiding. 12.30 p.m., luncheon and business meeting, Private Duty Section. 2–5. p.m., open session. Address, "Some of the Problems of the Private Duty Nurse," speakers to be announced. Address, "The Nurse in the Community," Professor Thomas Vesey Smith, Ph.D., University of Chicago. Address, "Steps Which Are Being Taken To Improve the Service of the Nurse in the Community," Laura R. Logan, Illinois Training School for Nurses, Chicago. 6 p.m., dinner, Elks' Club Auditorium, May Kennedy, presiding (open to Senior students and to laymen interested in nursing). 8 p.m., pageant, "The Inner Urge," a dramatization of the evolution of nursing written and directed by Mrs. Grace M. Loesby, Moline.

October 11, morning session, in charge of the Public Health Section, Sadie Strande, Chairman, presiding. 8 a.m., breakfast and business meeting, Le Claire Hotel. 9.30–11.45 a.m., open session; address, Anne Raymond, Field Representative of the School and Health Service Department, Cleanliness Institute, New York City; address, "Recent Steps in School Health Education," Mary L. Hahn, Supervisor, School Health Education, State Department of Health; address, Katharine Tucker, General Director, National Organization for Public Health Nursing. 11.15 two health films, "The Bent-fed Baby," "Breast Feeding." 12 m., Joint Lay and Public Health Nursing Luncheon, Harriet Fulmer, Supervisor, Cook County Bureau of Public Welfare, Chicago, toastmistress. Speakers: Mrs. Henry Ainsworth, Moline, Mrs. William R. Fringer, Katharine Tucker, New York City. 2–4 p.m., session in charge of Boards of Directors of Hospitals and Public Health Organizations. Round-table, topic to be announced. Session in charge of Illinois League of Nursing Education, Evelyn Wood, President, presiding. 2–4 p.m., open session, address, "Some Modern Trends of Education," Jules Maurtizen, Dean, Augustana College, Rock Island; address, "The Value of Psychiatric Nursing as a Method of Teaching the Student Nurse Mental Hygiene," Marion J. Faber, Illinois Training School for Nurses, Chicago; address, "The Value of Chemistry to the Nurse," J. P. Magnuson, Ph.D., Augustana College, Rock Island; address,

"A Survey of Experience Offered in Communicable Disease Nursing in the Accredited Schools of Nursing in Illinois," Charlotte Johnson, Superintendent, Durand Hospital of the McCormick Institute for Infectious Diseases, Chicago. 4, sight-seeing tour. 4.30, afternoon tea, Moline Public Hospital, Moline, Girls' Dormitory, Augustana College, Rock Island, St. Anthony's Hospital, Rock Island. 5.30 p.m., buffet supper, State Park, Blackhawk Watch Tower, Rock Island, Guests of Fifth District.

October 12, morning session in charge of American Red Cross Nursing Service, Mrs. Elspeth H. Vaughan, St. Louis, Mo., presiding. 9–12, reports of Illinois Local Committees on Red Cross Nursing Service; address, "What Home Hygiene Means to a Community," Mrs. Isabelle W. Baker, National Director Home Hygiene and Care of the Sick. Round-table for Instructors, Chairman, A. Louise Kinney, Assistant National Director, Home Hygiene and Care of the Sick. 9 a.m., round-table, "Possible Points in the Teaching of Ward Administration," Chairman, Gladys Sellew, Illinois Training School for Nurses, Chicago; round-table, "Case Studies as a Teaching Method," Chairman, Blanche Graves, Supervisor, Meyer House, Michael Reese Hospital, Chicago. 12.30 p.m., Red Cross Luncheon, Red Cross Headquarters, Moline. 2 p.m. closing business session, May Kennedy, presiding; unfinished business. 3 p.m., meeting of new Board of Directors.

Indiana: The Indiana State Nurses' Association will hold its annual meeting, October 11 and 12, at the Hotel Oliver, South Bend. The program is as follows:

October 10, 5 p.m., dinner and directors' meeting.

October 11, 8.30 a.m., registration. 9, opening session, Gertrude Updike, Vice President, presiding, business and reports. 11 a.m., Private Duty Section, Lelia Stokes, Chairman, reports of Central Directories, Indianapolis, Mrs. Huggins; Lafayette, Mrs. Goss; Fort Wayne, Mrs. Tudor; South Bend, Mrs. Rutherford; Evansville, Mrs. Smith; Terre Haute, Miss Hankins. 11.30, "Navy Nursing," Anna G. Davis, Navy Nurse Corps. 12, luncheon, Second District Association, hostesses. 2 p.m., "Nursing Service in Relation to the Community," Lyda Anderson, Executive Secretary, Detroit District, Mich.; discussion by representatives of the Community, the Registry, the Private Duty Nurse. 4 p.m., round-table for presidents, secretaries and treasurers of district and alumnae associations. 7 p.m., dinner and theatre party.

October 12, 8.30 a.m., unfinished business. 9, Public Health Section, Mary Williams, Vice Chairman, presiding. "Activities of State Department of Public Health Nursing," Eva F. MacDougall, Director; Helen Bean, Indiana Field Representative, American Red Cross; address, "Social Hygiene," Lenn J. Orr; discussion, Lucy Reilly; 2 p.m., address, "The Roll of Volunteers in the Public Health Nursing Program," Malinde Havey, American Red Cross, Washington, D. C.; discussion, Faye Nixon, Goshen, Helen Kennan Little, Logansport; demonstration, Testing of the Preschool Child, Mildred G. Smith, Staff Associate for the National Society for the Prevention of Blindness, New York; unfinished business; awarding of *American Journal of Nursing* prizes.

The Indiana League of Nursing Education will hold its annual meeting on October 10, Rosetta Graves presiding. The address of welcome will be given by Margaret Parker. The morning session will be occupied with business and reports. The topics for the afternoon session are: "Methods of Teaching Pediatric Nursing," Gladys Sellew, Illinois Training School for Nurses, Chicago; "Status of the Grading Committee and Its Probable Influence on the Nursing Profession," Laura R. Logan, Illinois Training School for Nurses, Chicago.

Iowa: The joint annual meeting of the Iowa State Association of Registered Nurses and the State League of Nursing Education will be held in Marshalltown, October 16–18. A splendid program has been planned. One full day will be given to the sectional meetings. Anna C. Gladwin of Akron, Ohio, Chairman of the Private Duty Section of the A. N. A., will be a speaker in the Private Duty Section. Dr. William DeKleine of the American Red Cross will speak in the Public Health Nursing Section, as well as on the general program. Elinor D. Gregg, Supervisor of Nurses of the Bureau of Indian Affairs, will appear on the general program. The plans of the Program Committee include a trip to the Tama Indian Reservation near Tama. Janet Geister, Director of A. N. A. Headquarters, will be present, and will assist in the organization of a State Lay Section. The committee has been particularly fortunate in securing Dr. Steiner of Grinnel College as banquet speaker.

Kansas: The Kansas State Nurses' Association will hold its annual meeting at the Hotel Lassen, Wichita, October 16–19.

This will be the sixteenth annual meeting of the State Association; the fifth annual meeting of the State League; and the tenth annual meeting of the Private Duty Section.

Louisiana: The annual meeting of the LOUISIANA STATE NURSES' ASSOCIATION will be held November 5–7, at the Hotel Jung, New Orleans, preceded by a meeting of the Advisory Council on November 4 at 9 a.m., and of the Board of Directors at 11.

November 5, 8 a.m., registration; 9, opening session with an invocation by Rev. Florence Sullivan, Dean of Loyola University; address of welcome by Mayor Arthur O'Keefe; business. 2 p.m., Private Duty Section, Cornelia Gravel, Chairman. An address will be given by Mary M. Roberts, Editor of the *American Journal of Nursing*.

November 6, morning, Private Duty Section, continued. Afternoon, Public Health Section, Maude Reid, Chairman.

November 7, morning, final business meeting. 7 p.m., Silver Jubilee banquet in the Jung Hotel Roof Garden at which the charter members will be the guests of honor. A history of the State Association will be read. All charter members are asked to communicate with Mrs. Clara M. McDonald, 2020 Toledano St., New Orleans. The six districts will entertain the Association at different times throughout the convention.

Massachusetts: The fall meeting of the MASSACHUSETTS STATE NURSES' ASSOCIATION is to be held in Northampton, at the Northampton Hotel on Friday, October 4. S. Lillian Clayton, President of the American Nurses' Association, is to be the principal speaker.

Michigan: The office of the STATE ASSOCIATION has been removed from Detroit to Capitol Savings and Loan Building, Lansing, where the General Secretary, Miss Wheeler, may be found.

Mississippi: The MISSISSIPPI STATE NURSES' ASSOCIATION will hold its annual meeting in Laurel, October 26–28. Ida F. Butler, from the American Red Cross, Anna G. Davis, Assistant Superintendent of the Navy Nurse Corps and Jane Van De Vrede, President of the Southern Division of the American Nurses' Association, will be present and address the Association. It always adds interest and enthusiasm to the meetings to have such national leaders present.

Missouri: The MISSOURI STATE NURSES' ASSOCIATION will hold its annual meeting at the Hotel Robidoux, St. Joseph, October 21–23.

Nebraska: The NEBRASKA STATE NURSES' ASSOCIATION will hold its annual meeting in Lincoln, October 18–19.

New York: *Quarterly News*, the official publication of the New York State nursing organizations was published for the first time, in July. It contains announcements and reports of interest to all the state members.

The NEW YORK STATE NURSES' ASSOCIATION will hold its annual convention in Buffalo, in joint session with the State League of Nursing Education and the State Organization for Public Health Nursing at the Hotel Statler, October 23–24. An outline of the program will be found on page 1145 of the *September Journal*. In addition to the subjects outlined there, we have the following additional items: The first session of the State Association will be opened Tuesday morning at 10 o'clock, by the President, Mrs. Genevieve M. Clifford. Tuesday afternoon, at 2.30, three different meetings are on the program. The League will meet with Mary Robinson, President, in the chair. Dr. May Ayres Burgess will deliver an address. The Organization for Public Health Nursing will convene for business and a discussion of "Milestones in Public Health Nursing," by Sara Kerr, Dr. Frances M. Hollinghead and David C. Adie, all of Buffalo. Another session of interest will be that of the Private Duty Nurses, with Mrs. Lena S. Clark, Chairman, presiding. Dr. Howard Osgood, Buffalo, will speak on "Communicable Diseases;" Grace Langhurst, Syracuse, will give a demonstration of "Communicable Disease Nursing Technic;" Minne E. Rosen, Consulting Dietitian, Buffalo, will speak on "High Lights in Special Diets." The Tuesday evening meeting will be an open session at the Buffalo Cemetery, Mrs. Clifford, presiding, with an address of welcome by Mrs. Richard Noye of Buffalo and a response by Alta E. Dines, as well as the Red Cross speakers, Dr. Green and Miss Noyes.

Wednesday at 9.30 a.m., the three associations will meet in joint session to hear a symposium on "Education." Three addresses will be given; "The Nursery School—Learning through Living" by Winifred Rand, Detroit; "Adult Education," Prof. George B. Neumann, Buffalo; and "Life Itself as Education," Dr. George A. Coe, Evanston, Ill. The afternoon sessions are as follows: The League of Nursing Education will hear, in addition to Miss Stewart's paper, a discussion on "The Head Nurse—Her Relation to the Hospital, Patient, Student and Herself" by Helen Wood, Laura Lewis, Blanche Edwards

and Marion Wells. The Advisory Council will meet at 3.30 p.m. to consider important questions.

On Thursday, at 3.30 p.m., there will be a final luncheon meeting of the State Association.

Several special breakfasts and luncheons have been planned. Tuesday at 12.30, Marion Sheahan, will preside at a luncheon for Public Health Nurses. The speaker will be Grace Anderson, President, Joint Vocational Service, New York. Wednesday, at 8 a.m., industrial nurses will meet for breakfast with Mary T. Dowling, New York. At the same hour, Grace Allison, Chairman of State Legislative Committee, will preside at a breakfast for District Legislative Chairmen. Two luncheons will be held at 12.30, Wednesday: One for Lay Groups with Mrs. Richard Noye, presiding, and Dr. May Ayres Burgess as speaker. The second luncheon will include the directors of registries and district chairmen of private duty sections. Emma Collins of Brooklyn, will preside; Julia Wilkinson is the speaker.

Thursday at 8 a.m., Miss Hicks, Executive Secretary, State Association, will meet the district presidents and secretaries for breakfast. A luncheon for school nurses will be held at 12.30 p.m., Thursday, with Edith Walker of Rochester, Chairman.

Several social events have been arranged. On Tuesday, the students will be taken by motor cars to Niagara Falls. Wednesday, the following trips have been arranged: The Buffalo at Lackawanna, ten served at Our Lady of Victory Hospital; Crippled Children's Hospital, ten served in Hospital Auditorium; Children's Hospital, to visit the Out-Patient Department, ten served at Nurses' Home. Wednesday evening at 7, a banquet with special entertainment has been arranged.

The following railroads: New York Central, Delaware, Lackawanna and Western, and Lehigh Valley, offer reduced rates of fare and one-half to all delegates who pay a going fare of more than sixty-seven cents. For further information write the Executive Office, 370 Seventh Ave., New York City.

North Carolina: The North Carolina State Nurses' Association held its annual convention, August 28-30, at Wrightsville Beach, with headquarters at the Seaside Hotel. The register showed at the conclusion of the meetings that 189 had attended. The 28th was devoted to Public Health, the 29th to League of Nursing Education, and the 30th to the Private Duty Section, with business sessions throughout the three days.

The program of each day was full and interesting with the following speakers: Dr. Laughinghouse of Raleigh, Dr. Hamilton of Wilmington, Mildred G. Smith of the National Society for the Prevention of Blindness, L. Casey Jones of Atlanta, on "The Connection between the Metropolitan Life Insurance Company and Public Health Nursing." A talk on "Life Insurance and Building and Loan" was given by A. B. Stallworth of New York; there was likewise discussion of the Harmon Foundation Annuity Plan. Other interesting speakers were Miss Mayer of the Navy Nurse Corps, whose address was illustrated with slides, Dr. Bessie E. Lane of Raleigh, and Miss Redwine. A very interesting pediatric clinic was held at Dr. Ledbury's private hospital. Outside of the business and papers, social features were interspersed, as well as the surf-bathing of which many took advantage.

The usual business was transacted, such as discussion of cases obtaining state relief. State Headquarters Secretary (an official position created last year) was more minutely discussed and Mary P. Laxton was appointed to serve as Executive Secretary. Lula West who has been both executive secretary and educational director was reappointed educational director.

Members were fortunate in having with them Dora M. Cornelison from the *American Journal of Nursing* who is making a survey of the entire state. She gave talks on her mission and outlined her itinerary so that each district would know when to expect her. Invitations for the next meeting were received from Winston-Salem, Moorhead City, Asheville and Greensboro. It was voted to accept Greensboro's invitation. Officers elected are: President, E. A. Kelly, Fayetteville; vice presidents, Mrs. Bessie D. Powell, Wilmington, and C. Woodhall, Raleigh; secretary, Mrs. Myrtle Roberson, Greensboro; executive secretary, Mary P. Laxton, Asheville; treasurer, Mrs. W. E. Shope, Asheville. League of Nursing Education—President, Elizabeth Connolly, Sanatorium; secretary, Elizabeth Hill, Statesville. Board of Nurse Examiners—President, Bessie Chapman, Greensboro; secretary, Mrs. Z. V. Conyers, Greensboro.

North Dakota: The North Dakota State Nurses' Association will hold its seventeenth annual meeting in Minot, at the Elks' Hall, October 30, 31, and November 1. Mary E. Gladwin, of Akron, Ohio, will be one of the main speakers. Dr. J. A. Myers of Minneapolis will also be there during part of the convention. A luncheon for ex-service

nurses is being planned. The first day will be given over to sectional meetings for the Private Duty and Public Health groups. The State League of Nursing Education is meeting at the same time. An interesting session is anticipated.

Oklahoma: The OKLAHOMA STATE NURSES' ASSOCIATION will hold its annual meeting in Ponca City, October 24-26. It is expected that the President of the American Nurses' Association, S. Lillian Clayton, will be a guest and speaker. All sections of the Association have prepared good programs, and Ponca City is planning to give a wonderful entertainment.

Pennsylvania: The GRADUATE NURSES' ASSOCIATION OF THE STATE OF PENNSYLVANIA will hold its twenty-seventh annual convention in joint session with the State League and the State Organization for Public Health at the Yorkstowne Hotel, York, October 21-25. The full program will be found on pages 1023, 1024 of the August *Journal*, with the exception that I. Malinda Harvey is taking the place of Miss Fox on the Red Cross program and the Private Duty Section has not as yet secured speakers.

Rhode Island: The present secretary of the RHODE ISLAND LEAGUE OF NURSING EDUCATION is Wilma B. Chapin, succeeding Miss Shaheen, who is no longer in the state.

Tennessee: The TENNESSEE STATE NURSES ASSOCIATION will hold its annual meeting in Nashville, October 14 and 15, with headquarters at the Andrew Jackson Hotel. The program is as follows:

October 13, 9 a.m., breakfast, Baptist Hospital Alumnae; automobile ride. 12.30, lunch Nashville General Hospital Alumnae. 2 p.m., meeting of the Board of Directors.

October 14, 8.30, registration. 9, opening session, Mrs. Corinne Hunn, presiding; invocation, Dr. W. F. Powell; address of welcome, Mayor Hillary E. House; response, Mentes Wayne; business and reports. 1.30 p.m., session at Vanderbilt Hospital, Edith Brodie, presiding;

"What Makes a Good Supervising Nurse," Mrs. Mary White, Knoxville, and an address by a student, Baroness Erlanger Hospital, Chattanooga; illustrated talk, "Navy Nurse Corps," Anna G. Davis; "What Your Alumnae Means to You," Mrs. Higgins, Chattanooga; "Modern Nursing Procedures," Student Nurses, Vanderbilt Training School. 4.30, tea, Vanderbilt Hospital Nurses' Home. 7 p.m., cabaret dinner, Andrew Jackson Hotel, Private Duty Nurses; "The Southern Division as It Fits in the General Plan," Jane Van De Vrede, President of Southern Division; "The Nurses' Place in the Federated Women's Clubs," Mrs. Arch Trawick.

October 15, 7 a.m., Public Health Section breakfast; address, "A Public Health Nurse's Day," Louise McCarney, Knoxville; Appointment of State Chairman. 7 a.m., Private Duty Section breakfast, address, "Twelve-Hour Nursing," Betty Geary, Knoxville; appointment of State Chairman. 7 a.m., Nursing League of Education breakfast; address by Julia Wright, Chattanooga; appointment of State Chairman. 8.30 a.m., general session, Mentes Wayne, first vice president, presiding; "What the State Health Department Is Doing," Dr. E. L. Bishop; Health Commissioner; "Recent Developments in Surgical Treatment of Pulmonary Tuberculosis," Dr. I. A. Biggers, Vanderbilt University; "Use of Calmette's BCG in the General Tuberculosis Program," Dr. John Overton, City Health Commissioner. "The Nurse and the Tuberculosis Program," Miss Martha Bounds, Memphis; "Health Teaching in Schools," Elma Reed, Peabody College, Nashville; "Metropolitan Welfare Activities as They Relate to the Field of Public Health," Isabelle Carruthers, St. Louis; "The Prevention of Congenital Syphilis," Mrs. Alma Scott, American Nurses' Association. 2 p.m., closing business session. 4.30 p.m., tea at St. Thomas' Hospital, St. Thomas Hospital Alumnae.

The convention will be followed by an Institute, the program for which will be found under the heading, Institutes and Special Courses.

Utah: The UTAH STATE NURSES' ASSOCIATION will hold its annual meeting in Salt Lake City, October 19, with afternoon and evening sessions. Members are looking forward to the meeting with Clara DeCou, who is to be the speaker at the annual dinner. The outstanding achievement of the Utah State Nurses' Association, during this past year, was the districting of the state. Under the leadership of the President, Mrs. Myrtle Horne, this work was begun and carried through successfully. Seven districts have been outlined, two of these are organized and are now handling their own problems. The membership of the Association has increased from 178 to 265. The Association put over successfully another venture, that of sponsoring a performance at a local playhouse, in order to raise Utah's quota for the hospital at Bordeaux, France. This not only raised the necessary amount, but through three short

radio talks, by the President, a brief history of nursing during the World War was heard and appreciated by many citizens. In addition to the contribution to the Bordeaux Fund, the theatre party financed the quota to the Grading Committee. The Association was proud in having two representatives at the International meetings in Montreal.

Vermont: The semi-annual meeting of the Vermont State Nurses' Association will be held on October 28, 1920, at the Athens Club Rooms, corner of Willard and Pearl Streets, Burlington. The morning session will open at 10.30. A program of special interest to private duty nurses is planned.

Wyoming: Phoebe M. Kandel, State Director of Nursing Education of Nebraska, has been secured by the Wyoming State Board of Nurse Examiners, through the courtesy of the Department of Public Welfare and the Board of Examiners in Nursing, to make the first survey of the schools of nursing in the state with the view of improving the instruction of the student nurses. This survey will be made during September.

By the act of the last legislature an appropriation was made which will be used to meet the cost of having the schools of nursing surveyed for two years. There are seven schools throughout the state, operated in connection with hospitals. They are located at Wheatland, Casper, Sheridan, Cheyenne, Kemmerer, Rock Springs, and Laramie. It will devolve upon Miss Kandel to see that the schools furnish proper training service to equip the nurses they turn out for efficient work in their profession. Among the states that have provided someone to evaluate the schools of nursing, Wyoming is the sixteenth.

District and Alumnae News

Illinois: Canton. The Graham Hospital Alumnae Association has recently been organized, composed of state registered nurses. Meetings are held the first Monday of each month at the Hospital. The Association has sixteen charter members and two honorary ones. **Decatur.**—The regular meeting of the Tenth District was held at the Decatur and Macon County Hospital, on the afternoon of September 2. Following the regular business meeting, reports were given from members who attended the International Council of Nurses Meeting in Montreal. A paper entitled "Rural Nursing from the Viewpoint of the Public Health Nurse" was given by Leone W. Ware, Chief Supervising Nurse, Division of Child Hygiene and Public Health Nursing, State Department of Public Health. Alice Dalbey, who recently returned from a three months' trip in Europe, gave a very interesting report of her visit to the Bordeaux Memorial.

Maine: Portland.—The Alumnae of the Maine Eye and Ear Infirmary held their September meeting on the 6th. The Nurses' Relief Fund Committee reported that this association of about fifty members had raised $114. The Committee for the Bordeaux Fund reported sending $23. The next meeting will be held October 4.

Michigan: Detroit.—The District held a meeting on September 6, at 51 West Warren Ave. Reports from the International Council of Nurses were given. The meeting on October 4 will be held at the Children's Hospital. On November 1, there will be an open forum for discussion of the subjects, "Is an Eight-hour Day for the Private Duty Nurse Practicable?," "The Apparent Apathy of Nurses in Their Organizations," "Support of a Community Nursing Program," "The Conflict of Loyalties in Professional Relationships."

New York: Binghamton.—Seventy-five Triple Cities' Nurses visited Ideal Hospital, when a meeting of District 5 was held there. Ella Stanbro of Buffalo spoke on the Official Registry of Buffalo and also traced the history of the Nurses' Club House. Reports of the International Congress were given by two representatives. **Syracuse.**—The regular meeting of District 4 was held at the new City Hospital, on September 9. An Institute for Private Duty Nurses was held at Syracuse Memorial Hospital, September 27 and 28. An interesting program was provided. Mr. Perry of the City Bank talked on "Savings," illustrating his talk with a movie. Miss Gardner gave a brief talk on the Annuity Plan for Nurses.

North Carolina, Asheville.—The Nurses' Association of District 1 held a regular meeting at the Nurses' Club on September 11. Miss Laxton gave an interesting report of the meetings of the I.C.N. **Goldsboro.**—Members of the staff of the Spicer Sanatorium of Goldsboro Hospital and members of the Goldsboro Hospital Board of Trustees were guests of the nurses of both schools and the graduate nurses of the city at a barbecue supper the evening of September 8. About 75 people were present. Harriet Kennedy wel-

crowd the visitors, reminding the members of the medical and nursing groups that it was the first time they had met on a social occasion. Dr. W. H. Cobb made a response. After supper Miss Cornelison spoke to the nurses present on "Keeping Up with What is New in Our Profession." She made it clear that the best way to do this is to use the *American Journal of Nursing*. On September 6, Miss Cornelison visited Spicer's Sanatorium to address the students. Viola Turnage gave an address of welcome in which she stated that the *Journal* is used as a text-book in the school. Roanoke Rapids.—The October meeting of the Eighth District will be held here on the 8th.

North Dakota: Bismarck.—Mrs. Mary Davis of Salina, Kans., has taken the position of Supervisor of Nursing Service at the Bismarck Hospital, succeeding Justine Granner, who is spending a year at Teachers College, New York.

Tennessee: Memphis.—District 1 held its annual meeting on September 12, when the following officers were elected: President, Hattie Shelby; vice presidents, Mrs. Henderson and Mattie Malone; secretary, Mrs. Fryer; treasurer, Blanche Fowler. Officers of the Private Duty Section are: Chairman, Miss Garibodi; secretary, Miss Richardson; treasurer, Teresa Keith. The directory is now located in Forest Park Apartment, 773 Court Avenue. The Memphis General Hospital Alumnae have chosen as officers: President, Myra Cushing; vice presidents, Ningle Elrod and E. G. Hinton; secretary, Elizabeth Nail; treasurer, Minnie Lee Nail. Chairmen of committees are: Nominating, Miss Musick; Program, Mrs. Veazy; Red Cross, Etta Williamson; Sick, Katherine Padgett.

Utah: Salt Lake City.—The Salt Lake District, or District No. 1, is now working out plans to begin an hourly nursing service in connection with the official directory. The Private Duty Section has added a 12-hour duty to its service and is now providing 10-hour, 12-hour and 20-hour duty.

Virginia: Richmond.—Frances Helen Zeigler, former educational director and assistant director of nurses, school of nursing and health, University of Cincinnati, on September 1, became Dean of the School of Nursing and Director of Nursing Service of College Hospitals at the Medical College of Virginia.

The I. C. N. Proceedings

THE Proceedings of the International Congress of Nurses, held in Montreal, last summer, will be printed in English and also in French, should there be a sufficient number of requests. As the material is so voluminous, the Directors have decided that in only a few exceptional cases will the papers be printed in full; digests, however, will be given of all, as well as of the discussions. Reports of most of the committees will appear in full. It is hoped that the Proceedings will be ready in November. The price will be $1.00. Orders should be sent to Miss Christine Reimann, Secretary, 14, Quai des Eaux-Vives, Geneva, Switzerland.

Deaths

Mrs. M. H. Dana (Elizabeth Ann Miller, class of 1911, Centenary Hospital, St. Louis, Mo.) on August 20, following an operation. After doing private duty for two years, Miss Miller came to Coffeyville, Kansas, as night supervisor at the General Hospital. In 1921 she took a course in Public Health at the University of Missouri School of Social Economy and, returning to Coffeyville, was made the Red Cross Public Health Nurse. In 1922, she was married, continuing her work with the Red Cross until her death. Mrs. Dana was a member of the State Organization for Public Health Nursing and of the Third District. At the time of her death she was secretary of the State Association for the second term. Mrs. Dana will be sadly missed in nursing circles in Kansas. She was a conscientious worker and her loyalty to the State Association was outstanding.

Mrs. Emma Goetz Meyers (class of 1907, Lutheran Hospital, Fort Wayne, Ind.) at her home in Chicago, of acute indigestion, September 19. Mrs. Meyers did private duty until her marriage. Burial was in Fort Wayne.

Martha C. Snyder (class of 1909, Lutheran Hospital, Fort Wayne, Ind.) on August 8, at her home in Columbus, Ind., from carcinoma. Miss Snyder was a private duty nurse, working in Indianapolis.

Ida M. Veit (class of 1902, Lankenau Hospital, Philadelphia) on June 21, at the home of her sister in Kitchener, Canada. Miss Veit had been engaged in institutional and private duty nursing until she took a position as infirmary nurse at Lafayette College, Easton, Pa. She had been ill for more than two years.

About Books

MATERIA MEDICA NOTEBOOK. By Mary Sewall, R.N. 35 pages. The J. B. Lippincott Company, Philadelphia. Price, $1.25.

THIS notebook is made up of thirty-five sheets of light-weight, colored cardboard (8½ inches by 11 inches), indexed for specific groups of drugs, *e.g.*, cardiac stimulants, cardiac depressants, etc. Each sheet contains a list of the commonly used drugs of a group, with a statement of their principal action.

The sheets are perforated for an ordinary loose-leaf folder. For class notes, blank sheets are to be inserted between the indexed pages.

Orange colored sheets are used for classifying those drugs which have a stimulating action while blue ones are used for depressants, it being the opinion of the author that the use of color in classification "attracts attention and intensifies impression."

As to the color factor, a point of disadvantage is seen, since many hospitals use different colored medication cards on their wards, and if these colors do not correspond to those suggested by the Notebook, confusion might easily arise in the mind of the student.

In the general arrangement of the indexed pages, the cardiac and respiratory drugs precede those of the central-nervous-system group. This does not seem logical since the action of many of the drugs of the cardiac and respiratory groups produce their effects through the action on the central nervous system, and they should, therefore, follow rather than precede the drugs acting upon the central nervous system. A modification of the author's arrangement could be made, however, by the individual instructor.

There are some schools of nursing in which students are not required to own a textbook of Materia Medica and it is probable, in such schools, that Miss Sewall's Notebook might prove of value in providing the students with a ready reference for the classification of drugs. However, in schools where students do own materia medica textbooks, it does not seem that this Notebook would offer any additional advantage or warrant the added expense, since practically all textbooks dealing with this subject classify drugs and present them in similar groups.

LEILA I. GIVEN, R.N., M.S.
Instructor, School of Nursing
Western Reserve University,
Cleveland, Ohio.

No mother needs to do without a very good text on the care of the baby when Carolyn Conant Van Blarcom's "Building the Baby" can be secured for fifty cents through the publicity service office of the Chicago *Tribune*. The material is simply stated, attractively illustrated, and entirely up to date.

This book promises to be a boon to the nurse in far away places who wants mothers to have a reliable, up to date, inexpensive, readable book on the care of little children, and one which does not make the task seem too difficult of successful attainment.

SARA B. PLACE, R.N.
Superintendent, Infant Welfare Society of Chicago.

Books You Will Enjoy

ISABEL ELY LORD

THORSTEIN VEBLEN'S death calls attention once more to *The Theory of the Leisure Class*, that remarkable, witty, ironical, searching study. Old, yes—but worth rereading. Many current phrases are taken from the volume, and it has had and will have a marked effect on American thinking.

Nobody writing today is more stimulating than Walter Lippmann. In *A Preface to Morals* (Macmillan, $2.50) he sets us thinking once more, and thinking in the way that helps toward the solution of our problems of life and conduct.

Another stimulating person is Stuart Chase. This time he offers us *Men and Machines* (Macmillan, $2.50). Is the machine age making us, or going to make us, both slaves and materialists? He's a witty man, is Stuart Chase, as well as one of fine mind and fine purpose.

After a generation of his wonderful work in Labrador, the man most of us still think of as Dr. Grenfell, though he is Sir Wilfred now, took a year to go around the world with his wife, and he tells us of it in *Labrador Looks at the Orient* (Houghton, $5). He tells of scenes and structures, but his interest is chiefly in people, so we get most about them, with many comments giving the writer's philosophy of life. The Near and the Far East are the subject of his book. The illustrations are numerous and unusually pleasing—evidently from photographs taken by some member of the party.

If you are really interested in our neighbor Mexico, or wish to be, by all means read Ernest Gruening's *Mexico and Its Heritage* (Century, $6). It gives a brief résumé of the history of the land, then turns to nearer days and pictures the people, their condition and customs, their health, their education, the troubled question of politics. It is written in an easy style, with many illustrative anecdotes, and with many fascinating illustrations from photographs. The book is heavy.

Mazo de la Roche's *Whiteoaks of Jalna* (Little, Brown) continues and completes *Jalna*. That book should be read first, to make *Whiteoaks* understandable. The ugly duckling, Finch the mystic, is the center of interest. Alas! Old Adeline is gone.

The Black Camel is Earl Derr Biggers's latest Charlie Chan story—and Charlie is one of the most entertaining of detectives (Bobbs-Merrill).

It is hard to find good stories for the teen-age boy or girl. Elsie Singmaster's *You Make Your Own Luck* (Longmans) is admirable.

Official Directory

International Council of Nurses.—Sec., Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

The American Journal of Nursing Company.—Offices, 370 Seventh Ave., New York.—Pres., Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee, Wis. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Mary M. Riddle, care American Journal of Nursing, New York, N. Y. Elsie M. Lawler, Baltimore; Sally Johnson, Boston; Mrs. Elsbeth Vaughan, St. Louis; Elizabeth G. Fox, Washington, D. C.

Committee on the Grading of Nursing Schools.—Director, May Ayres Burgess, Ph.D., 370 Seventh Ave., New York.

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